

The Falkland Islands Government

Public Health Strategy

2019 - 2021



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Acronyms & Abbreviations

AGs	Attorney General's
AMR	Anti-Microbial Resistance
ASD	Autism Spectrum Disorders
BMI	Body Mass Index
CE	Camp Education
C&I	Customs & Immigration
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
CPNs	Community Psychiatric Nurses
DHSS	Department of Health & Social Services
DMFT	Decayed Missing & Filled Tooth Index
DoH	Department of Health
DPED	Department of Policy & Economic Development
EMIS	Egton Medical Information System
EPO	Employment Protection Ordinance
EU	European Union
EURASFF	European Union Rapid Alert System for Food and Feed
ExCo	Executive Council
FC	Falklands Conservation
FCTC	Framework Convention for Tobacco Control
FICS	Falkland Islands Community School
FIG	Falkland Islands Government
FIMCo	Falkland Islands Meat Company
FIMNT	Falkland Islands Museum & National Trust
FIOGA	Falkland Islands Overseas Games Association
GP	General Practitioner
HIA	Health Impact Assessment
HMSC	Health and Medical Services Committee
HR	Human Resources
IJS	Infant & Junior School
KEMH	King Edward VII Memorial Hospital
MLAs	Members of the Legislative Assembly
MPC	Mount Pleasant Complex
MTO	Medical Treatment Overseas

NCD	Non-communicable Disease
NCMP	National Child Measurement Programme
NGO	Non-governmental Organisation
NHS	National Health Service
NIP	National Infrastructure Plan
PE	Physical Education
PH	Public Health
PHE	Public Health England
PWD	Public Works Department
RFIP	Royal Falkland Islands Police
SAERI	South Atlantic Environmental Research Institute
SHEU	Schools Health & Education Unit
SLC	Stanley Leisure Centre
STI	Sexually Transmitted Infection
UK	United Kingdom
WHO	World Health Organisation

Executive Summary

To support the community to enjoy a healthy lifestyle MLAs have set an objective within The Islands Plan 2018 – 2022 to implement a public health strategy to support health promotion and disease prevention. This strategy has been developed with this overall objective of implementation in mind.

This document takes an overview of what public health is and how a wide range of determinants impact our overall health outcomes.

In examining the general health profile of the Falkland Islands we have encountered difficulties in drawing evidence based conclusions as data has been scarce and often demographic markers are not available which might aid in identification if or where health inequalities exist.

We have utilised a four domains public health framework to examine the limited data around important health indicators for population health. We recommend that this framework is adopted in future to build a complete picture of robust data of all factors that impact health outcomes.

The four domains are:

- Improving Wider Determinants of Health
- Health Improvement
- Health Protection
- Health Public Health & Preventing Premature Mortality

In identifying some key themes it has become apparent that the Falkland Islands is at a very foundational stage of public health development. We have considered the need for investment in prevention and a shift in focus away from a more traditional medical model of health towards a complete systems approach. Utilising evidence from other jurisdictions we have also considered the cost of not acting on preventable causes of disease and incorporated an evidence based framework for building capacity in public health.

This has led us to four areas of strategic priority:

- Data Collection
- Capacity Building
- Enabling Healthier Choices
- “Health in All Policies”

Focusing on these four key areas will enable us to build a strong foundation to move public health forward for the benefit of the entire community.

What is Public Health?

In 1915 Winslow defined public health as “the science and art of preventing disease, prolonging life, and promoting health and efficiency through organised community efforts, so organising these benefits as to enable every citizen to realise his/her birth right of health and longevity.” This definition shaped the discipline of public health and 100 years later remains the standard.

The Alma Ata Declaration of Health for All and Ottawa Charter state that for public health to be effective it must:

- Recognise the key lead role of state linked to wider determinants of health (see **Figure 1**)
- Emphasise collective responsibility for health, its protection and disease prevention
- Be multidisciplinary
- Be partnership based involving, individuals, communities, voluntary, government and business sectors

The World Health Organisation (WHO) vision today is to promote greater health and wellbeing in a sustainable way, while reducing health inequalities and strengthening integration of public health services not only from those delivered in primary care settings but across broader sectors.

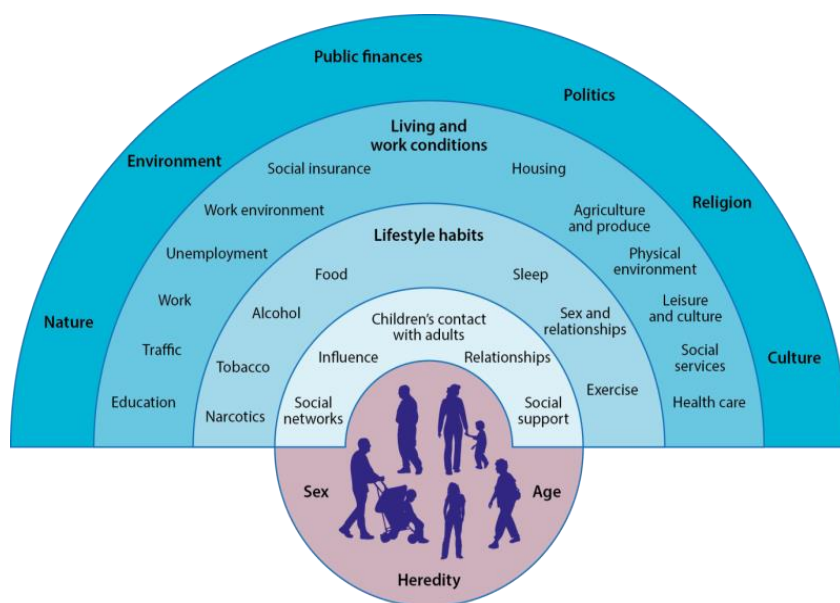


Figure 1. Determinants of Health (Dahlgren & Whitehead, 1991)

A comprehensive public health programme encompasses direct health services, community engagement, research, evaluation, surveillance, policy development and implementation. None of this can be achieved without political will and sustained resources. Public health programmes require some time to reach maturity and for health benefits to be observed in a population. Therefore sustainable capacity is essential to allow effective implementation from evidence based research and activities.

While many of the most challenging issues in public health today, such as smoking, poor nutrition and lack of physical activity could be reduced by individual behaviour change, increasingly it is recognised that there is a need to call on social and behavioural sciences to improve population health and wellbeing.

There is an increasing evidence base that many issues which impact negatively or positively enhance health have structural, social and behavioural determinants (see **Figure 2**). These range from the physical environments we live, work and play in; distribution of income; employment status; levels of and access to education; access and quality of health care; experiences and perceptions of the built environment; access to green space; access and provision of active transport; social behaviour; stigmas and discrimination.

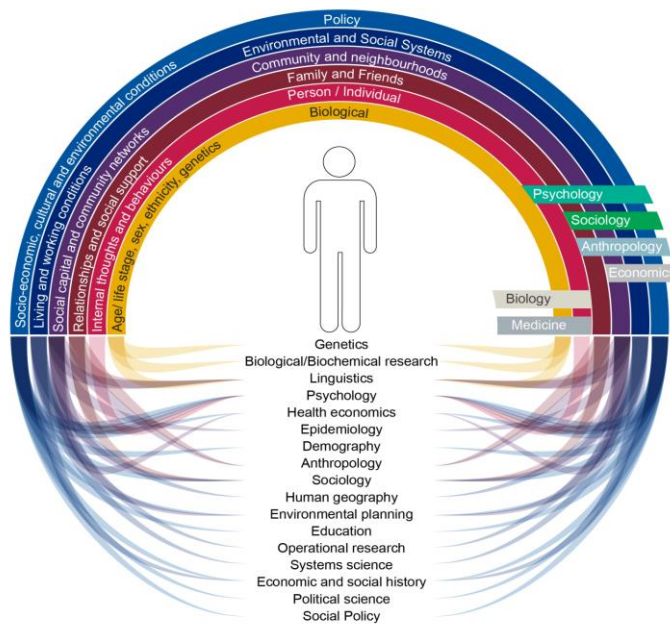


Figure 2. Conceptualising the contributions of behavioural and social science disciplines (Public Health England (PHE) 2018)

Link to The Islands Plan Vision (page 21)

- We will ensure that everyone within our community is supported to enjoy a healthy lifestyle;
- We will maintain and improve our existing resources and services, and invest in developments to support the current and future wellbeing of everyone in the Falkland Islands

Link to The Islands Plan Objectives (page 22)

- Implement a public health strategy to support health promotion and disease prevention
- Develop and implement a mental health strategy that recognises the importance of good mental health

Falkland Islands General Health Profile

According to the 2016 census the Falklands has a population of 3200, and is diverse with 60 different nationalities represented. While the majority of the population (2219) are permanent residents there is also a significant number (899) who reside here temporarily usually as work permit holders or as dependents of work permit holders. The combination of a small population and the transient nature of a significant number creates a challenge in gaining accurate assessments of population health.

Historically the Falklands has not had a strong data driven culture to produce annual population health statistics, perhaps in part as the nature of funding for health care has not called for it. A former Chief Medical Officer (CMO), Dr Roger Diggle noted in the 2000 Health of the Nation Report that there was inadequate collection of health statistics. In part he attributed this to not having the appropriate computer systems in place to achieve this but also noted that computer systems had been implemented and should improve the situation for future collection. The present system utilised for King Edward VII Memorial Hospital (KEMH) records is EMIS and while it holds a wealth of individual information, issues with the system means that data is unable to be collated, extracted and analysed for population health without the need for extensive personnel hours to do so. The system is due to be replaced shortly and configuration for reporting on health indicators has been included which should improve the situation provided personnel resource in the form of a data manager and a reporting schedule is adhered to.

Like many countries the costs associated with health care are rising, as an example cost coded to medical treatment overseas (MTO) was £477,929 in 2002/03 compared to £1,823,227 in 2017/18. More work needs to be done to ascertain the proportion of health care spend on preventable diseases to be able to establish if it is realistic to develop interventions around reducing costs associated with MTOs which may stem from preventable cause.

The 2016 census found that the majority of people reported their health to be very good or good (88%) and only 1% reported their health to be bad or very bad. 9% of the population (with an average age of 59 years) indicated that a long term health condition did impact upon daily living. While the proportion of the population with a long term health condition has not increased since the previous census in 2012 the significant impact on daily living has more than doubled, with those living in Stanley stating the impact was more severe.

Long term health conditions in the United Kingdom (UK) are more prevalent in those over 60 years and more severe in those that come from areas that suffer economic deprivation. The UK Department of Health (DoH) estimates that £7 out of every £10 spent by health and social care goes towards treatment and care of those with a long term health condition. The total cost of providing a health care service in the Falkland Islands was estimated to be £950 per head of population (Diggle 2003) but no distinction was made between acute and long term care.

Estimated life expectancy was reported to be 80 for females and 76 for males in 2014 (FIG Statistics Year Book 2014). The figures may need to be viewed with caution due to the size of the population and methodology used. Health inequalities have been demonstrated to impact upon life expectancy ranges and figures reported for the UK show this. Females in Chiltern, considered to be a wealthier area, have a life expectancy of 86.7 years while for those born in Middlesbrough, where social

deprivation is higher, it is only 79.8 years. A similar pattern is seen in males; in affluent areas such as Chelsea males can expect to live 83.3 years and those in Blackpool 74.7 years. There is insufficient evidence yet to draw conclusions on the impacts of wealth and the life expectancy in the Falkland's population.

One objective of The Islands Plan (2018-2022), via the implementation of a public health strategy, is to support healthier disease-free living in the community. Like many Westernised communities lifestyle diseases and demands of modern day living in the Falkland Islands impact upon the health of citizens. The Health of the Nation Report (2000) acknowledged that the Falklands were lagging far behind in disease prevention approaches with a need for a perspective shift from a sickness model.

There are limited research papers available on health in the Falkland Islands. KEMH has been able to provide some numbers from disease registers held within EMIS however it should be noted that they have indicated that they can't be 100% certain that these numbers are correct given the difficulties experienced with extracting information from EMIS; additionally ethnicity, usual place of residence or immigration status have not been identified.

While we have some indicators of health status, one of the key challenges in developing public health is that the data available is not robust and demographic information is missing. Better data collection with respect to differences between populations in Stanley and the Camp, ethnicity and immigration status would allow for more targeted approaches and improve resource allocation for health improvement.

Hypertension

Cases of hypertension on the disease register are 611, with the majority of cases being observed in males, 333 (KEMH 2018). This is in contrast to a set of findings in 1979, where low prevalence was observed in males and the researchers suggested this was due to an active outdoor lifestyle (King & Bleaney 1984).

Obesity

King & Bleaney (1982) found obesity rates low, attributed to high levels of outdoor work. Obesity rates (BMI \geq 30) currently are estimated to be around 1 in 3 of the population above 16 years (KEMH 2018). A previously published figure utilised to establish a baseline for The Islands Plan 2010 – 2015 indicated that 44% of the population was obese and a further 8% morbidly obese. It cannot be assumed that this is an improvement in population health as in both cases the demographics of the sample population are not stated therefore potentially the shift could be attributed to population migration changes.

A school screening programme was undertaken in 2016 surveying the Falkland Islands Community School (FICS) students and Year 3 students at the Infant & Junior School (IJS) and Camp Education (CE) which indicated that 27% of students in Year 3 and 35% in FICS were overweight or obese. The results however should be interpreted with caution due to the small sample size and the high number of opt outs, 29 out of 158 (18%) in FICS. A second school screen occurred in 2018 and results received from KEMH (2018) indicate 31% in IJS and 35% in FICS are categorised as overweight/obese however it is not confirmed how many students opted out of the screen or if the same methodology was used for both screenings.

Diabetes

KEMH (2018) indicate that they currently have 169 cases on the diabetes register, 92 males and 77 females. Further analysis was provided on 150 cases which indicated 140 (89 males, 51 females) were Type 2 and 10 (3 males, 7 females) Type 1. Of the Type 2 cases 80% of patients are obese (37% mildly, 24% moderately, 19% morbidly) and a further 13.5% overweight. In the Type 1 cases 40% are obese (30% mildly, 10% moderately) and 30% overweight.

Cancer

It is difficult to identify if all cancers are on the increase, due to limited comparative data; however EMIS figures (2018) indicated there are 147 current cases, the most common being skin cancer, (48 cases), followed by breast cancer, (28 cases). However this is from the total population and does not distinguish between permanent and temporary residents or provide for further demographic breakdown; it is therefore impossible to track prevalence in the permanent population. Previously published figures suggested that over a 12 year period between 1989 – 2000, there were 85 cases (excluding non-melanoma skin cancer), this study considered the population who had been resident for more than 5 years (Swerdlow, Elsby, Qiao 2001).

Tobacco & Alcohol Consumption

Figures from both the 2012 and 2016 census suggest that tobacco and alcohol consumption are decreasing. It is noted that these figures are self-reported but that trends in self-reported health behaviours are a valid estimate of true prevalence. Figures from import data for cigarettes and tobacco would also support this decreasing trend in consumption over this period. The import data however has also indicated that while the import of cigarettes has continued to decline through 2017/18, tobacco imports have increased since 2015/16. The import data for alcohol 2002 – 2018, while showing an overall decrease does indicate variation year on year.

Sexual Health

Data collected for an MSc project between 1st June 2017 and 30th June 2018 indicated that 402 sexually transmitted infection (STI) screens were requested and undertaken in the population aged 16 – 77 years. This included 218 from males and 184 from females via a new initiative the Xpert CT/NG kit which allows patient self-sample collection. The purpose of the study was to compare uptake to the previously delivered service of clinician sampling. Uptake was significantly improved after introduction of the self-sampling particularly in younger age groups 20-29 years. It should be noted that the study included data collected from the military base Mount Pleasant Complex (MPC) as well as the civilian population. The researcher noted that positive results were higher in males - 39 from MPC and 13 from KEMH compared to 2 females from MPC and 10 from KEMH.

Mental Health

Observations made by King & Bleaney (1982) indicated numbers of mental health cases were low, which they suggested was due to low levels of stress from living a traditional Islands lifestyle . A more recent paper however indicates that mental health disorders including anxiety, depression, alcohol abuse and dementia have increased over the ten year period 2005 – 2015. Cases of enduring

mental illness are reported as low and have decreased during this same 10 year period (Rimicans & McInerny 2018).

Headline results are pending for a survey undertaken in 2017 by the University of Stirling considering mental health and wellbeing 'Health in Mind – Falkland Islands Mental Health & Well-Being Survey 2017'. This data set will provide further valuable insight into the well-being of the population.

Dental Health

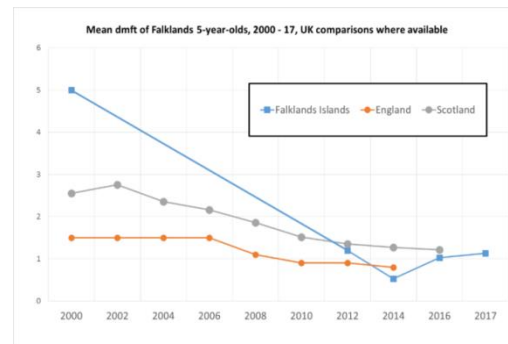
An area where the Falkland Islands has seen a dramatic improvement through a concerted effort is in dental health of young children.

Spotlight on Dental Health

Dental health in 2000 was poor in 5 year olds and a paper published by the CMO at the time indicated that while poor dental health is generally associated with poverty in the Falklands it could be attributed to affluence with children being provided with too many sugar sweetened beverages and sweets (Diggle 2003).

In response to concerns regarding the number of dental caries in young children an oral health strategy for the Falkland Islands was introduced

The Tooth Report (2002) and concerted efforts have seen levels of decayed, missing and filled tooth index (DMFT) decrease to comparable levels with England and Scotland (see graph). The first systematic survey was undertaken by the dental department in 2013 of 5, 12 and 15 year olds. On-going surveys in children aged 12 have occurred at regular intervals and the DMFT has decreased from 0.9 in 2013 to 0.3 in 2017.



The improvements in dental health are likely a combined result of outreach education, improved recall, introduction of fluoride varnish at dental appointments and the introduction of tooth brushing with fluoride toothpaste at nurseries (Jones 2018).

Despite this improvement in the dental health of children there is presently no data on adult dental health and this is a recommendation of the updated strategy. Fluoridation of the Stanley water supply remains a recommendation along with ensuring appropriate resources in personnel, funding and training to maintain the improvements made (Jones 2018).

Although there is no available data to quantify the amount of sugar in the diet of residents of the Falkland Islands, the availability of sugar sweetened beverages and foods is plentiful in the Islands and consideration should be given to measures to discourage excessive consumption. These may include options to explore voluntary agreements along the lines of a responsibility deal as seen implemented in the UK with retailers or legislative options such as a sugar tax, along with wider education programmes to inform the public of the health consequences of excessive sugar consumption.

Current Public Health Provision in the Falkland Islands

The CMO is the Government's chief advisor on health issues including public health. KEMH performs critical functions related to public health (for example prevention of disease outbreaks, provision of sexual health services, population screening and vaccination programmes). Other functions which KEMH undertakes relate to environmental health and food safety although they report that many of these services are reactive. Other food safety aspects, for example inspection and certification of fish and meat products, are undertaken by the Veterinary Service.

Many of the staff at KEMH, as part of their roles, provide elements of public health (for example the Pharmacy runs the smoking cessation service and the Practice Nurse team a weight management programme). Limited health promotion activities are undertaken however as personnel resource is often stretched, which often doesn't provide for sustainability or adequate monitoring and evaluation.

There is a notable absence of population health data to help inform the development of Government policy and decision making in relation to resource allocation for disease prevention and health promotion. The lack of data makes drawing comparisons around the health status of the Falklands population with other populations difficult.

Currently no official public health unit is in place that could support the development of public health delivery and monitor population health changes. Prevention and health promotion, enabling people to remain healthier for longer, is an objective of The Islands Plan 2018-2022. This could be progressed further via a public health unit as part of multi-agency responsibility including, but not limited to the health and social services, schools, leisure industry, community and voluntary groups, and Public Works (PWD) (in the creation of public parks/green spaces and active transport (cycling/walking) routes). At present, there is no single focal point with the responsibility for implementing a strategy or for monitoring results and outcomes.

Legislation in Place

There is some legislation in place however some of the ordinances are not recent and therefore may require reviews or revisions in the future. The most relevant ones to public health are indicated below.

- Public Health Ordinance 1894
- Board of Health By-Laws 1937
- Dairy Produce Ordinance 1938
- Infectious Diseases Ordinance 2003
- Smoking (Prohibition) Ordinance 2010
- Children and Young Persons (Tobacco) Ordinance 2007
- Abusable Substances (Young Persons) Ordinance 1994
- Prohibition of Psychoactive Substances Order 2013
- Misuse of Drugs Ordinance 1987
- Public Health (Ships) Regulations 2010 (made under the Public Health Ordinance)

The Public Health Ordinance 1894 has been coded as D1 thus identifying it as a topic area which may require review. This current strategy does not propose a change in the role of the CMO or the HMSC as it relates to the Public Health Ordinance 1894.

The Board of Health By-Laws 1937 includes items which are no longer applicable to today's society for example the removal and disposal of night soil.

There are also in place various ordinances and legislation around export of products, primarily fish and meat from the Islands. For example all meat products produced for export by the Falkland Islands Meat Company (FIMCo) are subject to European Union (EU) standards.

Legislation and Regulation Gaps

Imports of meat, fruit and vegetable products from outside the EU require a permit. Permitted consignments, most often of South American origin are inspected by the Bio Security team for bio hazards only, therefore even if the quality is deemed poor or out of date the goods are not prohibited from reaching the importer who will decide if they will be sold to the general public.

Import products produced in the EU are tracked via the EURASFF (European Union Rapid Alert System for Food and Feed) so if there is a recall an alert e-mail is received via the system allowing action to be taken promptly to advise the general population and recall goods.

Locally produced food is not subject to any voluntary or mandatory labelling. A minimum standard (voluntary or mandatory) would be an ingredients list and advice if the product contained allergens. FIMCo meat products which enter the local market do include an ingredients list but do not indicate the presence of allergens.

There is a reluctance to over-regulate in the community however consideration might be given to exploring options that as a minimum inform consumers of the basic ingredients and the presence of allergens in products. Currently one local supplier has begun to introduce some information on allergens on one line of products carried.

It is important to note that some retailers have been extremely proactive in some areas of health promotion prior to any regulation such as placing cigarettes out of sight and restricting sales to those 18 and over even when the legal age was still 16 for purchasing.

Developing a Public Health Strategy Linked to The Islands Plan 2018 – 2022

To support achievement of The Islands Plan objective of ensuring that everyone in the community is supported to enjoy a healthy lifestyle, a public health strategy is recommended utilising the four domains framework which underpins evidence based practices and considers the delivery of public health care programmes (see example **Table 1.**) with an emphasis on a shared responsibility for health.

Public health activities for health protection, health improvement and disease prevention are guided by an assessment of need in the community. Developing a complete picture of health status, influences of health status, health related behaviours and the influences of the environment in which the community lives, works and plays is key to understanding where to target resources. Adopting the framework (see **Table 1.**) has the potential to allow us to develop that complete picture by tracking indicators throughout the life course and tracking trends that influence health outcomes.

Table 1. Public Health Four Domains Framework

Domain 1	Domain 2	Domain 3	Domain 4
Wider Determinants of Health	Health Improvement	Health Protection	Healthcare Public Health
Objective: Reducing health inequalities and improving factors which impact upon health and wellbeing	Objective: People are assisted to live healthier lives, make healthier choices and inequalities are reduced	Objective: Population health is protected by the prevention and control of infectious disease; regulation is adhered to or implemented for clean air, water and food provision; prevention of or dealing with environmental hazards or threats	Objective: Improving public health service delivery supported by evidence based practice; appropriate planning and prioritising; engaging in research, audit and evaluation.
Indicators: Are taken across the life course	Indicators: Are taken across the life course	Indicators: Are taken across the life course	Indicators: Are taken across the life course

A framework such as this however relies upon the cornerstone of public health research; robust data to build an evidence base and health information management systems being in place with the capacity and personnel to extract relevant data for continuous surveillance and monitoring purposes. A requirement for annual data collection and reporting of health statistics will be essential.

In developing this initial Public Health Strategy, we have considered:

- Information available about the health status and burden of disease in the Falkland Islands
- Alignment to existing and developing plans and strategies
- Engagement with stakeholders to identify areas of public health concerns
- Legislation and regulation in place and the need for potential development of voluntary or mandated regulation
- Current service provision
- Utilising best practice examples and guidance to shape recommendations

Table 2. utilises the public health four domains framework described above to analyse key findings on the current situation in the Falkland Islands and recommends actions based on best practice that would provide an opportunity to improve public health provision.

Many FIG departments have reported during stakeholder engagement that they do not have the personnel resource to spend time researching through paper or database records to collate the requested information, reinforcing the need for a change in how health information is collected and stored for future monitoring of long term health outcomes for the population.

As an example of constraints around resourcing for service delivery the Pharmacy ran a very successful StopTober campaign in October. Including an increased emphasis on planning, advertising and delivery of service for two months prior and throughout the month of October this resulted in uptake of cessation clinic appointments increasing by 30%, however due to a lack of staffing resource they have not been able to sustain the momentum of the campaign to target the hard to reach groups in the community such as young (16- 25) smokers.

For some of the indicators, data availability and time constraints have limited the amount of research that could be undertaken. These represent areas where additional work would be an advantage to formulate and understand the complete picture of all the life course indicators for health. A complete overview via the collection and analysis of appropriate data from the health indicators would aid in decision making and pinpoint where resources are most needed.

Table 2. An Overview of Key Findings to Matched Health Indicators with Recommended Actions			
*note health indicators are chosen from internationally recognised standards and recommended actions are made utilising best practice			
Domain 1: Improving wider determinants of health:	Following a range of health indicators through the life course is key to identifying where health inequalities exist when considering wider factors which impact health and wellbeing. Annual reporting of statistics is required to establish a robust baseline set of data and establish trends.		
Health Indicator & Rationale	Existing Programmes/Policies/Regulations	Key Findings	Recommended Actions
<p>Indicator: Children in low income families</p> <p>Rationale: Children in low income families are more likely to suffer premature death and poorer health outcomes as adults.</p>	<ul style="list-style-type: none"> Family allowance: £77/child/month (2019/20 figure) Working credits for low income earners up to £34/week (2018/19 figure) Childcare credits for low income households: up to £34/week for one child; £53/week for 2+ (2018/19 figures) Welfare allowance Universal no-charge health care Minimum wage from 1st January 2020 will be £7.03 Winter fuel rebate programme Rent and service charge rebate for FIG housing for those eligible 	<p>The Social Policy Advisor undertook a welfare review which has considered issues such as:</p> <ul style="list-style-type: none"> Number of families earning below the living wage threshold After FIG support the number who remain below this threshold <p>Anecdotal evidence from health care and education staff suggests that in some cases mothers are returning to work very early post-partum from financial need, and that some children maybe arriving at school hungry and others are missing out on leisure opportunities. While we can't conclude that this is down to socioeconomic circumstances there is a potential that it could be a factor.</p>	<p>Develop public health intelligence to fill a knowledge gap with annual monitoring of the number of children living in families where income is below the threshold.</p> <p>Improve community awareness of what support is available to those most in need.</p>
<p>Indicator: Pupil absence in compulsory school age children (aged 5 to 15 at the start of the school year)</p> <p>Rationale: Education</p>	<ul style="list-style-type: none"> Recent introduction of nursery regulations to improve quality of early childhood care Childcare subsidies introduced in 2018 for nursery and wraparound care Universal free of charge 	<p>A survey undertaken by SHEU (2011) reported that 13% of pupils at FICS enjoyed "hardly any" of their lessons; 17% didn't know what GCSEs to take or didn't expect to take any; 39% wish to continue on to higher education after Year 11; 42% wished to train in a skilled job; 27% to find employment as soon as possible at the end of Year 11.</p>	<p>Pupil absence data received from IJS (2013 – 2018) and FICS (2012 – 2018) revealed that absence rates at IJS over this period range from 7.8% - 6.1% in 2017 – 18. In FICS during 2017-18 was 10.7% having decreased since a peak of 18.1% in 2014 – 15.</p> <p>Continue to collect and analyse annual data from IJS and FICS to monitor attendance and inform strategies if deemed necessary to minimise absence.</p>

<p>attainment is influenced by attendance, quality of education and socio-economic circumstances. Educational qualifications are a determinant of an individual's labour market potential, which in turn influences income, housing and resources.</p>	<p>education for compulsory school age children</p>		
<p>Indicator: 16-18 years olds not in employment or training.</p> <p>Rationale: Younger people not engaged in training or employment are at risk of a range of negative health outcomes, including depression.</p>	<ul style="list-style-type: none"> • Universal free of charge tertiary education available for all with permanent resident status, including living allowances. • Access to funding for 6th form is available to those who achieve the required level of academic performance • The Training Centre provides a range of qualifications offered both locally and via distance learning, careers advice and an apprenticeship programme • CDS programme (under review) 	<p>Census data 2016 reports 66 individuals in the age range 16-19 who were "not working for other reasons", an increase of 31 since the 2012 census however over half were students in full time education or training.</p> <p>Further analysis reveals that there were 3 people in the age range 16-19 years who were unemployed.</p>	<p>Publicise and inform community of opportunities to access funding and advice and opportunities for apprenticeship programmes or career development.</p> <p>Current information on the FIG website on further, higher education and training opportunities would benefit from updating.</p> <p>Continue to monitor to develop public health intelligence to identify where trends are.</p>
<p>Indicator: Employee sickness absence.</p>	<ul style="list-style-type: none"> • The Falkland Islands Employment Protection Ordinance (EPO) 1989 • Employers' Liability 	<p>FIG is the largest employer in the Falklands with 525 full time employees and a total of 728 employees including part-time and casual.</p> <p>The data set for sickness absence in FIG is incomplete and the data</p>	<p>Develop public health intelligence with an initial data collection stage to establish a baseline and trends of absence from "Fitness to Work" logged under specific defined categories.</p>

<p>Rationale: Absenteeism Impacts both on the employer with a loss of productivity, potential loss of a skill base and additional costs in recruitment and retraining if the employee becomes long term sick. For the employee there is a loss of earnings and the impacts on emotional and social well-being.</p>	<p>(Compulsory Insurance) 1996</p> <ul style="list-style-type: none"> • Employers' Liability (Defective Equipment) 2006 • Employment of Children Ordinance 1966 • Employment of Women, Young Persons and Children Ordinance 1967 • Employment Protection Ordinance 1989 • Equal Employment Rights Ordinance 1998 • Sex Discrimination Ordinance 1998 • Minimum Wage Ordinance and Regulations 2013 • Workmen's Compensation Ordinance and Regulations 1960 	<p>below shouldn't be taken as representative for the whole organisation but merely providing a general overview of what has been reported. Of the figures submitted covering 220 employees over the last 3 years 2589 days, averaging 863 annually, have been lost to sickness absence. Of that figure half are employed in the education sector, who average per employee/per year 1.84 days compared to 6.01 days for the remaining sectors.</p> <p>Reasons for absence are not routinely recorded by employers, including FIG, which means we don't currently have a baseline or knowledge on reasons for absence. As a bench mark, figures from the UK indicate that the average of days lost per employee has decreased from 7.2 in 1993 to 4.4 in 2013. New Zealand is similar with a current reported figure of 4.5 days/employee.</p> <p>There appears to be a lack of awareness across employers of the fundamental role of occupational health and workplace interventions contributing to overall health improvements, improving employee retention, reducing absenteeism and increasing productivity.</p> <p>Via the Chamber of Commerce, one private sector company made contact to provide an overview of their efforts to reduce absenteeism, increase retention and add value for employees. Atlink Ltd, a company with 10 full time employees invest a significant amount per year on staff training and are currently in the final stage of developing a three tier approach to employee health and wellbeing in addition to their international certification in quality management and British health and safety standards. Tier 1 occupational health pre-employment medicals; Tier 2 developing a health surveillance care package; Tier 3 health and wellbeing in the workplace, options which they are investigating in this area are time to walk to work, subsidising cycle purchase, providing fruit in the staff rest area and flexi-hours.</p>	<p>Encourage the utilisation of a tool such as the Workplace Health Needs Assessment https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/674851/Workplace_Health_Needs_Assessment_2018.pdf to allow employers to conduct an assessment of employee wellbeing.</p> <p>Develop a pilot programme for workplace wellness and identify one FIG department and one private sector company to implement the programme. This would allow for an assessment of impact on employee absenteeism and productivity. A workplace wellness programme could include elements on making and enabling healthier choices as well as techniques to reduce workplace stress.</p>
<p>Indicator: Adults of working age 18 - 64 with a learning disability/in contact with mental health or social services who live in stable and appropriate</p>	<ul style="list-style-type: none"> • Provision of support to vulnerable adults in the community from Social Services, District and Community Psychiatric Nurses • Charitable trust Acorns provides community 	<p>CPNs estimate that there are currently 10-20 adults in the community who live independently or in a family home with support who have a special educational need or neurodevelopmental disorder. However they advise it is difficult to be exact as this number may not include some individuals who may have an autism spectrum disorder (ASD) but have not received a formal diagnosis.</p> <p>Additional they advise that issues with EMIS recording make it difficult</p>	<p>Develop public health intelligence to establish a baseline and trends of referral to the multidisciplinary team.</p>

<p>accommodation.</p> <p>Rationale: Improves their safety and quality of life while reducing risks of social isolation a factor known to impact on well-being.</p>	<p>activities and support</p> <ul style="list-style-type: none"> • Social Services provide assistance with applications for Welfare Assistance and Attendance Allowance • Employment Programme • Vulnerable persons unit under development 	<p>to adequately report these statistics at a population level.</p>	
<p>Indicator: Levels of offending and re-offending.</p> <p>Rationale: Strongly associated with wider determinants of health and deprivation</p>	<ul style="list-style-type: none"> • Probation Service 	<p>A data request was made to the Royal Falkland Islands Police (RFIP) however they confirm that they have not recorded statistical information on re-offending rates in the past but do intend to in the future via the Probation Service.</p> <p>They have been able to provide statistics for the period 2015 - 2017 which indicate total crimes reported in 2015 of 158, rising to 162 in 2016 and then decreasing to 134 in 2017. Of those they further reported that 63 (in 2015), 54 (in 2016) and 40 (in 2017) were considered to be alcohol related.</p>	<p>Request annual stats from Probation Service to build up a trend picture relating to offending and re-offending.</p>
<p>Indicator: Death or injuries from road accidents.</p> <p>Rationale: Road accidents are a major cause of preventable deaths particularly in younger age groups and those in lower socioeconomic groups.</p>	<ul style="list-style-type: none"> • FIG road building and maintenance plan • National infrastructure plan (NIP) • RFIP run cycle safe courses once a year and utilise school liaison visits to highlight road safety to children • RFIP highlight dangers of speeding/drink driving through verbal interactions with local media • RFIP regularly undertake speed checks with radar surveillance 	<p>Figures supplied by the RFIP indicate that in the period between Jan 2011 and end of Oct 2018 there were 3 fatalities and 32 serious casualties as a result of road traffic collisions.</p> <p>Serious casualties may be transferred by aeromed for appropriate or specialist treatment. KEMH has been unable to confirm information relating to the number of patients referred or an estimate of costs from the MTO which may relate to road accidents.</p>	<p>Annual monitoring of statistics related to road accidents to build up a picture and establish trends.</p> <p>In conjunction with RFIP identify the common causes for road traffic collisions and develop educational and community awareness programmes which will aim to improve road safety for all users.</p> <p>Advocate for the inclusion of dedicated cycle/walk routes in new developments encouraging “active transport” thereby increasing the amount of physical activity a population undertakes and reducing the number of vehicles on the road.</p>
<p>Indicator: Fuel</p>	<ul style="list-style-type: none"> • Winter fuel allowance – 	<p>The Treasury have supplied data from 2017 & 2018 to the Social Policy</p>	<p>Annual monitoring of both fuel costs and family income</p>

<p>poverty.</p> <p>Rationale: Low income links to negative health outcomes.</p>	<p>entitlement for pensioners and those in receipt of level B or C Attendance Allowance</p>	<p>Advisor for a current piece of work around benefit contribution to low income households in the welfare review.</p> <p>In both years the majority of claimants (88 in 2017 and 102 in 2018) are retirement pensioners however a small number (4) are of working age and in receipt of an Attendance Allowance. To be eligible for the full allowance the total household income from all sources must not exceed £16,800. People with income levels between £16,800 - £17,260 are eligible for a partial allowance. Those with an annual income above £17,260 are not eligible for the winter fuel allowance.</p>	<p>levels.</p>
<p>Indicator: Utilisation of outdoor space for physical activity and health reasons</p> <p>Rationale: A wide evidence base highlights the beneficial impact to mental and physical health of being able to access outdoor space.</p>	<ul style="list-style-type: none"> • The Stanley Common has preserved a large area of land for public use • Community access to private land (with land owners permission) • Falklands Conservation run a conservation and environmental education group for youths, the Watch Group • Falkland Islands Museum & National Trust (FIMNT) run a youth outreach group Past Finders to encourage exploration and learning in the younger generation • Various groups and clubs encourage outdoor activity e.g. Falklands Outdoors, Ramblers, Dog Walking Groups 	<p>Anecdotal reports of “feeling better” from people who utilise the outdoors for leisure activities including walking, gardening, sports and tourism. King and Bleaney (1982) suggest that the low levels of obesity found in the Falkland Islands in the late 1970s could in part be due to the high levels of outdoor work undertaken at that time.</p> <p>A current project entitled Natural Capital Assessment undertaken by the South Atlantic Environment Research Institute (SAERI) considers the questions of human use and interaction with the natural environment. The report is due in March 2019.</p> <p>Children’s play park at Drury Street undergoing an upgrade following collaboration of local community fundraising by Essence of Our Community, private sector business and FIG.</p> <p>Team Tranquil are fundraising for a “Trim Trail” around Stanley.</p> <p>Many local sports clubs and activity providers utilise the outdoors however there has been no assessment on the impacts to health.</p> <p>For the first time since the 1950s the 2016 census recorded growth in the Camp population with an increase of 9%.</p>	<p>Consider utilising the finding from SAERI as a baseline. Collect and collate attendance data from groups and clubs to further evidence usage.</p> <p>Investigate with the tourism sector if opportunities exist to monitor local tourism access to outdoor space related to health.</p> <p>Develop programmes in conjunction with leisure providers, environmental researchers, conservation charities and tourism to encourage the population to utilise the outdoors for health benefits.</p>

Domain 2: Health Improvement	<p>The object of health improvement is that people are assisted to live a healthier disease-free life. This is perhaps the area in which well planned, monitored and evaluated initiatives aimed at the general population and specific sub-groups could potentially have the most positive impact for the entire community. There is considerable need to shift medical and political thinking, to reorient the health service from treatment to prevention. Evidence from other jurisdictions shows that investing in prevention is often considered low priority as results are accrued over a much longer timescale and demand for treatment is not immediately reduced.</p>		
Health Indicator & Rationale	Existing Programmes/Policies/Regulations	Key Findings	Recommended Actions
<p>Indicator: Low birth weight of full term babies.</p> <p>Rationale: Low birth weight is associated with risk of developmental issues and poorer health outcomes in later life.</p>	<ul style="list-style-type: none"> • Antenatal care programmes • Referral overseas if appropriate to care requirements 	<p>Population level data from the current EMIS system cannot be retrieved with confidence. In addition there are a number of overseas referrals in each year and data recording maybe inconsistent upon return to the Islands. KEMH have been unable to confirm the % spend of the MTOs on referrals for pregnancy care and birth, neither do we know if referrals are made in areas which could potentially benefit from an earlier intervention for example pre-pregnancy weight management programmes.</p>	<p>Begin data collection to establish a baseline and trends.</p> <p>Consider implementation of programmes such as the First 1000 days which are being adopted by many nations to ensure that children receive the best start in life (pregnancy, 1st & 2nd year). An example of the programme adopted in Ireland can be view by following the link. https://www.first1000days.ie/</p>
<p>Indicator: Breastfeeding rates.</p> <p>Rationale: Breastfeeding is considered to be beneficial for both baby and mum with both physical and psychological benefits. Breast feed babies receive a perfectly balanced nutrition and have lower rates of gastro-intestinal and respiratory infection and studies have indicated that breast feed children also have lower levels of obesity in childhood. Benefits to the mother are a quicker return to pre-pregnancy weight, and the potential to lower risk of breast and ovarian cancer.</p>	<ul style="list-style-type: none"> • Postnatal care programmes • Baby clinics • Health Visitor (post currently vacant) 	<p>Data covering previous 12 months from the Chief Nursing Officer (CNO) suggest that at the six week check in the previous year (2017/18) 9 mothers were breast feeding, 8 were mixed feeding and 8 had opted to bottle feed.</p> <p>Financial pressures and the need for an early return to work may be instrumental in some mothers being discouraged from breast feeding despite it being the cheaper option.</p> <p>In the UK 73% of mothers (NHS 2017) are reported to start off breastfeeding. The above data would suggest in the Falklands the figure in 2017/18 was 68%, however this figure may not include mothers referred overseas and not yet returned to the Islands.</p>	<p>Data collection to establish baseline and trends.</p> <p>Further research would be beneficial to establish what influences a mother's choice to breast or bottle feed.</p> <p>Develop materials that inform new parents of assistance entitlements.</p> <p>Consider implementation of programmes such as the First 1000 days which are being adopted by many nations to ensure that children receive the best start in life (pregnancy, 1st and 2nd year). An example of the programme adopted in Ireland can be view by following the link. https://www.first1000days.ie/</p>

Breast feeding builds a strong emotional bond between mother and baby.			
<p>Indicator: Smoking status in pregnancy.</p> <p>Rationale: Smoking is known to have detrimental effects on growth and development of the baby as well as impact on the health status of the mother.</p>	<ul style="list-style-type: none"> • Antenatal care programmes • Smoking cessation service provided by the Pharmacy 	<p>Data from the CNO covering previous 12 months (2017/18) indicates 15 were non-smokers, 6 ex-smokers and 3 smoking during pregnancy, one of whom managed to quit post-delivery. Smokers are provided with information on the cessation service ran by the Pharmacy.</p> <p>The Pharmacy do not currently have carbon dioxide monitors which can monitor impacts on the foetus. The Pharmacy Technician would like to introduce these as the evidence base is strong that they can provide a visual aid which motivation for smokers to quit.</p>	<p>Annual data collection to monitor trends.</p> <p>Consider options to target smokers to encourage and support attempts to quit for example introduction of visual impact tools such as the carbon dioxide monitor.</p>
<p>Indicator: Excess weight in children.</p> <p>Rationale: Children who are overweight or obese have significant increased risk of becoming overweight or obese adults with risks for increased chronic disease development earlier in life. They often experience increased risk of social isolation and low self-esteem with poorer mental well-being often as a result of teasing and bullying.</p>	<ul style="list-style-type: none"> • School Nurse • Health Visitor (post currently vacant) • Provision of PE in curriculum • KEMH weight management clinics 	<p>A data set was produced in 2016 from a school screen however results should be interpreted with caution due limited reach in the target population and small sample size, 29 out of 158 (18%) children did not attend for screening at FICS and only Year 3 in IJS were screened. In Year 3, 27% of children were classified as overweight/obese, while 35% of the FICS students screened were overweight/obese.</p> <p>A second screen was undertaken in 2018 and clarification is being requested on the methodology and the total number of opt outs. A comparison is made for the cohort group Year 3 in 2016, and the current Year 5, however it is not confirmed that individuals within the cohort have remained substantially the same, therefore it is not possible to draw conclusions from this data.</p> <p>Results received from KEMH indicate that in the 2018 screen 31% of children in IJS and 35% of FICS are overweight and obese.</p>	<p>Develop public health intelligence to fill knowledge gap with annual monitoring.</p> <p>Adopt a standardised methodology to provide data which is reliable and valid and can establish a trend picture over time. Utilisation of the world class NCMP (National Child Measurement Programme) https://www.gov.uk/government/collecti- ons/national-child-measurement- programme is recommended.</p> <p>In collaboration with other providers develop health and well-being campaigns aimed at families and children.</p>
<p>Indicator: Smoking prevalence.</p> <p>Rationale: Smoking is a major cause of premature death and preventable illness.</p>	<ul style="list-style-type: none"> • Smoking cessation service provided by the Pharmacy • Smoking (Prohibition) Ordinance 2010 • Smoke-Free Policy within the Health and Social Services Department (DHSS) • Taxes on imports 	<p>Self-reported smokers in the adult population 16 years and over have decreased from 22% in 2012 to 18% in 2016. Smoking prevalence is higher in males than females (census 2016).</p> <p>FICS believe a number of their current students are underage smokers however they have not been able to establish numbers. SHEU (2011) found that 32% had tried smoking or were smokers.</p> <p>Customs data supports the downward trend between 2012 – 2016, however there has been a rise in imports of tobacco since 2016,</p>	<p>Develop health promotion plans which include monitoring and evaluation to target at risk groups.</p> <p>Census data provides a good overview of trends however best practice international recommendations are for more frequent monitoring.</p> <p>Advocate for further implementation of a</p>

		<p>potentially due to lower import taxes on this product. DHSS introduced a smoke-free policy in 2017, covering premises, buildings and grounds. Currently they are the only FIG department to have a policy in place which also covers grounds.</p>	<p>smoke free policies to include grounds as per the example implemented by DHSS.</p> <p>Consider implementation of recommendations deemed appropriate received from PHE to align to WHO's Framework Convention on Tobacco Control (FCTC). http://apps.who.int/iris/bitstream/handle/10665/42811/9241591013.pdf;jsessionid=AC606459CAAFFD52E0B19488E5228D42?sequence=1</p> <p>Consider an increase on tobacco duties to match duty on cigarettes.</p>
<p>Indicator: Alcohol consumption.</p> <p>Rationale: Consumption of excessive alcohol is a major risk factor for non-communicable disease (NCD) development, impacting both physical and mental well-being.</p>	<ul style="list-style-type: none"> Alcohol awareness programmes facilitated by the CPNs Individual referral options GP support services Taxes on imports 	<p>Self-reported alcohol consumption has seen a decrease from 72% in 2012 to 65% in 2016 in the population 16 and over. 20% of drinkers consume more than the recommended amount per week; this was most apparent in the younger population (16-24) in Stanley and in the over 65's in Camp (census 2016).</p> <p>SHEU (2011) reported that 32% of FICS students had consumed alcohol in the 7 days prior to the survey, with 18% reporting getting drunk with a mean alcohol intake of 10 units.</p> <p>The CPN's report no clear trend in the annual number of referrals linked to alcohol use between 2012 – 2017.</p> <p>Crime related to alcohol use has fallen from 40% of total cases in 2015 to 30% of cases in 2017.</p> <p>The general trends seems to be a decrease in consumption and recent crime figures related to alcohol are falling however the number of cases referred to the CPNs indicates annual variation with 39 in 2012, 23 in 2013, 39 in 2014, 32 in 2015, 51 in 2016 and 30 in 2017.</p> <p>Advertising of alcohol products is commonplace in local media (print & social) and in store.</p> <p>The 'Health in Mind – Falkland Islands Mental Health & Well-Being</p>	<p>Develop public health intelligence by continuing to monitor, drawing information from annual import data and sales data.</p> <p>Develop campaigns which aim to build community knowledge on the impacts of harmful alcohol consumption.</p> <p>Carry out further work with retailers with the aim of developing a voluntary code around restricted advertising and limiting promotions on alcohol.</p>

		Survey 2017' asked questions relating to alcohol use. When available this data set will provide further valuable insight into the well-being of the population.	
<p>Indicator: Drug use.</p> <p>Rationale: Drug abuse like excessive alcohol consumption is causally linked to development of disease and psychological issues.</p>	<ul style="list-style-type: none"> • Individual referral options • GP support services 	<p>Historically it has been claimed that the Falklands is a drug free society and the Government website claims that problems of drug misuse are virtually unknown. However mental health workers have indicated that they are seeing cases related to past and current drug use. Along with the recent arrest reported in the press, this would indicate that the Falkland Islands are no longer drug free. However the extent of the problem remains unknown.</p> <p>SHEU (2011) found that 4% of FICS students had reported being offered cannabis and 5% that they had been offered other drugs. With a total of 13% of FICS students reporting that they had taken some form of illegal drugs</p> <p>The 'Health in Mind – Falkland Islands Mental Health & Well-Being Survey 2017' asked questions relating to drug use. When available this data set will provide further valuable insight into the wellbeing of the population.</p>	<p>Develop public health intelligence to fill knowledge gaps around use and reasons for drug use.</p> <p>The Health in Mind headline results will provide a useful baseline from which to build on.</p>
<p>Indicator: Activity levels</p> <p>Rationale: Activity levels, as a health behaviour are highly modifiable. Inactivity is strongly associated with NCD development.</p>	<ul style="list-style-type: none"> • A wide range of options are available in the community to support activity participation across age groups • Two fitness facilities, the Government run Stanley Leisure Centre (SLC) which includes a swimming pool and a military facility at Hillside Camp • Community classes including chair based exercise sessions provided by the Physiotherapists • PE provision by FICS and IJS/CE as well as after school clubs • Numerous sports clubs and activities (indoor and 	<p>While it has been possible to confirm membership numbers for SLC (561), with a further 103 members at Hillside Camp unfortunately this doesn't indicate what percentage of the population are actually active or if they achieving the minimum amount of recommended physical activity for health.</p> <p>SHEU (2011) indicated that 98% of FICS students responded that they had undertaken physical activity on at least one day in the previous 7 and 91% that they did so more than once in the previous week. 82% reported that they enjoyed physical activity 'quite a lot' or 'a lot'.</p> <p>PE provision at school could not be extended further without impacting on core subjects or lengthening the school day.</p>	<p>Utilising the UK guideline of 150 minutes of moderate activity or 75 minutes of vigorous activity undertake an initial health and lifestyle survey to establish a baseline for current activity levels.</p> <p>Develop health promotion plans around activity, including monitoring and evaluation in conjunction with partners.</p> <p>Develop relationships with activity/ sports clubs to investigate feasibility of research and data gathering around participation levels, for example utilisation of technology to monitor exertion levels during activity.</p>

	<ul style="list-style-type: none"> outdoor) Falkland Islands Overseas Games Association (FIOGA) events Local sponsorship of events e.g. Standard Chartered Marathon 		
<p>Indicator: Nutritional status.</p> <p>Rationale: A diet of poor nutritional quality is a major contributor to NCD development, including development of some cancers, cardiovascular disease, obesity risk and Type 2 diabetes.</p>	<ul style="list-style-type: none"> KEMH weight management clinic Diabetes clinics with UK based specialist support delivered via Skype 	<p>Anecdotally the Falkland Islands traditional diet of meat, potatoes and vegetables, while high in saturated fat from red meat, was most likely preferable to the now Westernised diet of highly processed foods items that form a large part of what is currently available to purchase.</p> <p>There is no data to suggest if the population meets requirements for recommended intakes for example 5-a-day for fruit and vegetables or within limits for certain nutrients - for example the adult recommended salt intake should be less than 6g (around 1 teaspoon) per day.</p>	<p>Conduct an initial health and lifestyle survey to establish some baseline data.</p> <p>Develop health promotion plans related to nutrition in conjunction with partners for a wide variety of settings (for example, nurseries, schools, workplaces and community venues). These plans to include monitoring and evaluation which can contribute to the evidence base.</p>
<p>Indicator: Excess weight in adults.</p> <p>Rationale: Overweight and obese adults are at risk of NCD development.</p>	<ul style="list-style-type: none"> KEMH weight management clinic GP Referral service when available qualified personnel in post at SLC 	<p>Figures from EMIS (2018) suggest around 1 in 3 adults is obese (BMI ≥ 30) however KEMH are not confident that this figure is correct. If it is correct this would indicate a decrease from previously reported baseline figures in the Islands Plan 2010-15 which suggested that 44% of the adult population was obese with a further 8% morbidly obese.</p> <p>There is currently no provision of the GP Exercise Referral scheme from KEMH to SLC due to a lack of personnel with appropriate qualifications at SLC.</p>	<p>Conduct an initial health and lifestyle survey to establish attitudes and perceptions around weight and health.</p> <p>Develop health promotion plans in conjunction with partners which focus on improved health outcomes for all. These plans to incorporate mechanisms for monitoring and evaluation.</p>
<p>Indicator: National screening programmes.</p> <p>Rationale: These programmes allow identification of apparently healthy individuals who may be at risk of a disease or health condition</p>	<ul style="list-style-type: none"> PHE guidelines are being followed at KEMH https://www.gov.uk/topic/population-screening-programmes 	<p>Call up age for breast cancer screening is 47 rather than 50 as in the UK due to the cycle of the equipment coming to the Islands only once every 3 years.</p> <p>Programmes for bowel screening use faecal occult blood sampling.</p> <p>Screening is offered to all eligible individuals and generally 3 reminders letters sent to encourage attendance.</p>	<p>Monitoring and reporting of take up rates is required with the goal of achieving 100% uptake by the target population.</p>
<p>Indicator: National health checks for over 40's.</p> <p>Rationale: As the</p>	<ul style="list-style-type: none"> Over 40s health checks programme in place 	<p>KEMH undertake to invite all individuals over the age of 40 for health checks. Coverage is likely to be lower in Camp due to ease of access of services. Repeat reminders are not consistent. Information is recorded on individual records but not collated at a population level.</p>	<p>Monitoring and reporting of take up rates is required to aim for 100% population coverage.</p>

<p>population ages risk factors increase for chronic disease development. Programmes such as the over 40's checks raise awareness, allow for early detection and intervention.</p>		<p>KEMH staff run drop in screening sessions in store, on specific health days, drop-in clinics throughout the year and at Farmers Week for all age groups to aid early identification of disease development. Data is collected from event days and entered into patient records with individual follow up where required. Population level analysis is not routinely undertaken as staff report there is insufficient personnel resource to do so.</p>	<p>Data on screening coverage, detection and intervention to be collected in a format for analysis and evaluation of population health.</p>
<p>Indicator: Injuries due to falls in people aged over 65 and over.</p> <p>Rationale: Falls can account for a large proportion of hospital admissions in older people and can impact long term health outcomes.</p>	<ul style="list-style-type: none"> • District nursing • Community support services • Physiotherapy services • Occupation Therapist 	<p>No specific data is currently available from EMIS. Health care workers indicated that data entered into EMIS may well reflect incidences of falls resulting in admission while in hospital or sheltered accommodation. However the data may not include falls which have occurred at home but didn't result in an admission.</p>	<p>Develop public health intelligence to fill knowledge gap with annual monitoring.</p>
<p>Indicator: Self-rated health and illness.</p> <p>Rationale: People with higher rates of overall health have lower rates of illness, recover quicker and generally have improved physical and mental health.</p>	<ul style="list-style-type: none"> • Self-reported data collected in census 2016 for first time 	<p>Self-report data is provided in the 2016 census which indicates that the majority of 88% rated their overall health as good or very good. While this figure seems to be positive for health, many of the NCDs that impact on today's society are considered to be silent illness i.e. having no or few symptoms prior to diagnosis e.g. Type 2 diabetes, hypertension.</p> <p>9% of the population (247 individuals) indicated restrictions to day to day activities from long term illness with 76% (188 individual) indicating little impact and 24% (59 individuals) indicating a lot of impact on daily activities. There is no specific distinction in this self-reported data of physical or mental well-being.</p> <p>Headline results due early 2019 for Health in Mind Survey will provide further insight into mental health and wellbeing.</p>	<p>Many lifestyle diseases observed in modern society are considered to be silent illnesses, i.e. having no symptoms prior to diagnosis e.g. Type 2 diabetes and hypertension. Therefore it is important to monitor health status to identify changes and trends.</p> <p>Develop health promotion plans, including elements of monitoring and evaluation to target population groups around physical and mental well-being in conjunction with community partners.</p>

Domain 3: Health Protection	The object for this set of indicators is that the population's health is protected from major incidents and other threats, whilst reducing health inequalities.		
Health Indicator & Rationale	Existing Programmes/Policies/Regulations	Key Findings	Recommended Actions
<p>Indicator: Air pollution.</p> <p>Rationale: Poor air quality can impact upon respiratory health especially in children. The pollutant of greatest concern for public health is particulate matter (PM) present in vehicle emissions.</p>	<ul style="list-style-type: none"> • Kyoto Protocol 	<p>National Atmospheric Emissions Inventory has monitored since 1990 on an annual basis. Falkland Islands emissions are the 2nd lowest World-wide and it is considered that they could not be lowered further without impacting on quality of life in the Islands.</p> <p>Air pollution is monitored for greenhouse gas emissions but localised testing for road traffic emissions is not currently undertaken.</p>	<p>In the absence of localised monitoring, pollution from road traffic could still be reduced by focusing on reduction via supporting development of environments which are friendly for active transport (cycling or walking).</p> <p>Green (hedge) fencing has also been demonstrated to reduce the impact of pollution from road traffic on humans and therefore could also be encouraged in high pedestrian areas such as central Stanley.</p>
<p>Indicator: Population vaccination coverage.</p> <p>Rationale: Coverage is closely related to levels of preventable communicable disease levels in a population.</p>	<ul style="list-style-type: none"> • KEMH follows the NHS schedule https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699392/Complete_immunisation_schedule_april2018.pdf 	<p>Anecdotally KEMH report a high take up, they estimate at least 90% of vaccination coverage in the population, although they are not able to extract any data to confirm this from the current clinical records system, EMIS.</p>	<p>Annual take up rate are monitored and reported to establish trends.</p>
<p>Indicator: STI rates.</p> <p>Rationale: STIs such as chlamydia can cause avoidable sexual and reproductive ill health.</p>	<ul style="list-style-type: none"> • Self-sampling tests • Clinician specimen collection 	<p>At the beginning of 2018 KEMH switched from clinician led specimen collection to patient self-sampling methods. This change along with a publicity campaign has seen an increase in uptake of screening, particularly in females aged 20-29years. Infection detection rate is higher in males. Males between the ages of 20-29 years continue to be considered a hard to reach group.</p>	<p>Targeted outreach to at risk groups.</p> <p>Continued annual monitoring and reporting.</p>
<p>Indicator: Incidences of notifiable disease.</p> <p>Rationale: Collation of information provides for disease monitoring and provide early warning of potential outbreaks</p>	<ul style="list-style-type: none"> • Infectious Disease Ordinance 2003 	<p>Incidences of notifiable disease are made to the CMO however there is no public reporting. A data request was made to KEMH for the data but to date has not been received.</p>	<p>Develop public health intelligence to fill knowledge gap with annual monitoring and reporting.</p>
<p>Indicator: Sustainable</p>	<ul style="list-style-type: none"> • National Infrastructure Plan 	<p>The information around this indicator gathers data from a wide variety of</p>	<p>Foster an understanding across sectors of</p>

<p>living. Rationale: A cross sector urban plan promotes healthy environments for people to live and work in. Social, environmental and economic considerations form part of a healthy sustainable development plan.</p> <p>NOTE: This indicator is about bringing together many aspects of socioeconomic and environmental factors that impact on overall health outcomes. The overall aim is to achieve a common understanding across sectors of health impacts and to develop collaborative decision making.</p>	<p>(NIP)</p> <ul style="list-style-type: none"> • Town Plan • FIDC – renewal energy grant for businesses • Renewal energy provision • Kyoto Protocol • Water safety achieved in Stanley via following WHO guidelines and EU testing guidelines • Environmental NGO projects • Community groups such as Plastic Free Stanley, Falkland Islands Wise Waste • Limited range of testing for environmental hazards • Board of Health By-Laws 1937 	<p>sources. The Board of Health, while not disbanded has not met since 2013; previous meetings held a couple of times per year and included the CMO, Veterinary Office and representatives from Public Works and Environmental Planning.</p> <p>The Town Plan makes reference to defining green space however there is a lack of emphasis on the need to develop these spaces to most benefit the health of the community.</p> <p>Active transport provision does not appear to be a feature of the current Town Plan. Road safety has been flagged as a current barrier to cycling and walking.</p> <p>The pathology lab at KEMH is able to undertake some water and food testing however their range of tests is limited in part due to a lack of staff and the need to prioritise clinical testing over environmental. They are able to advise on the detection of pathogens or bacteria however are not able to provide interpretation of results.</p> <p>The CMO acts as Environmental Health Officer however reports that the service is reactive and no spot checks are undertaken at premises providing food to the community.</p> <p>The water supply in Stanley undergoes regular testing as recommended by WHO guidelines. Camp consumers can send in test samples to KEMH but they are not obliged to. The Water supervisor would like to see water fountains placed in key areas around Stanley to aid access to drinking water this would have an added advantage of potential reduction of purchasing of single use plastic.</p> <p>A waste management strategy is under development which will consider the impacts and management of hazardous waste.</p>	<p>broader impacts on health from a wide range of sources with a view to developing collaborative approaches to improving health by viewing all health considerations in decision making across sectors i.e. “Health in All Policies”.</p> <p>Linked up working across Government and the wider community to develop healthy living and working environments for current and future generations.</p>
<p>Indicator: Antimicrobial resistance (AMR)</p> <p>Rationale: AMR is considered a global health threat that is endangering the prevention and treatment of infections</p>	<ul style="list-style-type: none"> • KEMH follow guidelines on antibiotic prescription from a UK based Microbiology Adviser (Dr Matthew Dryden) 	<p>Annual summaries of general use and resistance compiled by the Laboratory Deputy/Quality Manager and presented to Dr Dryden and the GP practice meetings.</p>	<p>A data set of antibiotic consumption has been provided from Pharmacy 2010 – 2018 and is currently with Statistician for analysis.</p>

Domain 4: Healthcare Public Health and Preventing Premature Mortality	This set of health indicators focus on healthcare delivery indicators alongside preventing ill health and preventable early death whilst reducing health inequalities.		
Health Indicator & Rationale	Existing Programmes/Policies/Regulations	Key Findings	Recommended Actions
<p>Indicator: Infant mortality (under 1 year)</p> <p>Rationale: Early intervention and prevention to reduce the risk of infant mortality will improve the life chances, health and well-being of both mother and baby</p>	<ul style="list-style-type: none"> • Ante/Post-natal care • Health visitor (post currently vacant) • Immunisation schedule (see link Population vaccination coverage) • Baby clinics 	<p>Dr Diggle noted in the Health of the Nation report (2000) that neonatal and childhood death rates are low and would place the Falklands in line with the best care rates in the world, indicating a high quality of health care service.</p>	<p>It is acknowledged that a single death would impact dramatically on a statistical picture around this indicator. However as an indicator reflective of health service quality it would be beneficial to collect annually and report every five years.</p> <p>CNO reports that increased focus on early interventions would assist new parents to develop a wide range of skills which would be beneficial to infant health and wellbeing.</p>
<p>Indicator: Proportion of 5 year olds free from dental decay</p> <p>Rationale: Tooth decay is predominantly preventable and decay levels are an indication of early life interventions</p>	<ul style="list-style-type: none"> • Dental Health Strategy 	<p>(See Page 8) Spotlight on Dental Health</p>	<p>Continued commitment to investment in the dental health strategy.</p>
<p>Indicator: Mortality rates in under 75s from preventable causes.</p> <p>Rationale: Many diseases are linked to lifestyle e.g. cardiovascular disease, some cancer, liver disease, respiratory disease and therefore</p>	<ul style="list-style-type: none"> • PHE guidelines followed for best practice https://www.gov.uk/topic/population-screening-programmes 	<p>The existing clinical records system is unable to extract population level data on incidences of mortality from preventable causes.</p>	<p>Develop public health intelligence to fill knowledge gap with annual monitoring.</p> <p>Develop and implement health promotion programmes linked to lifestyle disease development from individual behaviours.</p>

there is a potential for early interventions			
<p>Indicator: Health rated quality of life for older people (over 65).</p> <p>Rationale: An ageing population requires a focus on preventing ill health, preserving independence and promoting well-being</p>	<ul style="list-style-type: none"> • District nursing • Development of a new extra care facility • Acorns • Community Support Services 	<p>The census 2016 asked for the first time for self-ratings of health and for those >65 years 61% rated their health as very good/good; 35% fair; 4% bad/very bad. No significant difference was observed between those living in Stanley and Camp.</p>	<p>Develop public health intelligence to fill knowledge gap with annual monitoring.</p> <p>This indicator under best practice is measured utilising the EuroQoL 5D survey which includes: mobility, self-care, usual activities, pain/discomfort, anxiety/depression. See guidance via https://euroqol.org/wp-content/uploads/2016/09/EQ-5D-5L_UserGuide_2015.pdf</p>

It should be noted that many of these recommended actions relate to data collection, monitoring and reporting. The new clinical data management system from Patient Source has been requested to be configured to produce population level health statistics. It will be imperative that a data manager is in place and ensures that a reporting schedule is adhered to in the new system.

Key Themes Emerging

The majority of public health services are delivered by DHSS however there is a need for reorienting of the health service towards more preventative approaches and a need for reframing and acknowledgement at government level that a healthy community requires a complete systems approach. A complete systems approach draws on internal organisational resources, collaborative decision making across government and building external partnerships in the community.

There is currently a lack of community engagement, qualitative indications received from stakeholders and the general public suggest that the community does not feel that Government is overly concerned with the health status of its citizens. This creates an issue with attempting to generate a shared emphasis of collective responsibility for health. Public health communications need to be tailored both to inform the public about appropriate choices for the best health outcomes and to ensure that the community is listened to. This will enable the Government to develop an understanding of the best approaches to framing public health messages and delivering them in a way that is accessible and persuasive.

There are significant, well documented challenges with the current clinical management records system at KEMH including an inability to be able to extract and analyse the relevant data for public health purposes.

It is not clear whether historical data from the EMIS system or paper records will be transferred into the Patient Source system successfully. As reported in this document we have not been able to establish baselines for many important health indicators due to both availability and quality of data. Data and research are vital components to support informed decision making, policy development, and service delivery. Therefore, we propose that the first priority of a dedicated public health resource would be to conduct the necessary population health surveys and work with KEMH as it implements the new system, in order to establish the baseline information.

In the interim, it is appropriate to move forward with a whole population health promotion approach with a focus on prevention of diseases linked to lifestyle and supporting healthy aging via provision of wellbeing for both physical and mental health.

There is currently only a small annual budget (£10,000) for health promotion, which currently sits with DHSS. Due to a somewhat fragmented approach and insufficient personnel this has been underspent in the last two financial years. We recommend a more focused approach, including forward planning for health promotion and evaluation of delivered initiatives.

A best practice approach is recommended to be adopted for future health promotions:

- Evidence based assessment of need
- Adequate resourcing – personnel and funding
- Population priorities from an evidence base
- Outcome identification
- Planning for delivery of an intervention
- Consistent implementation and monitoring
- Evaluation – process, impact, outcome, capacity, economic

The Case for Change to Improve Population Health

The Falkland Islands is a modern and westernised society, we share the same concerns as others that if we do not act to improve the health status of the population the costs to health care will continue to rise. While at this stage we are not able to quantify what that rise might be as an example the NHS in the UK estimates that unless the rise in obesity is halted the direct cost is projected to rise from £6.1 billion (2014- 2015) to £9.7 billion by 2050 with the wider cost to society of £49.9 billion per year.

Referring back to **Figure 1.** the main drivers for health outcomes are considered to be socio-economic and environmental (50%); followed by individual health behaviours (30%) (i.e. if we smoke, drink alcohol, what we eat, whether we are physically active and poor sexual health) and the contribution from health care; access to and quality (20%). While this figure of 20% in relation to health care indicates great improvements in the health care system it also highlights a need for a change in how we approach population health improvement i.e. population health improvement needs to be rooted in what drives our health outcomes.

A wider view is now proposed which considers Health in All Policies and the targeting of interventions for individual behaviour change outside of the traditional model of the health care system i.e. transitioning from a medical model of health to a complete systems approach.

Investing in prevention enables people to stay healthier and independent for longer. With an ageing population, this is an important consideration as ill health creates an increased burden on health care budgets. Investment in public health can be part of the solution to reduce that cost burden while at the same time promoting health and well-being a key part of the vision of The Islands Plan 2018-2022.

What is the cost of not acting on preventable disease?

Direct health costs and the indirect social costs form the evaluation of the total cost for health however we are not in a position in the Falkland Islands as yet to be able to directly calculate these costs. There are some international examples we can consider for guidance as the evidence base continues to grow to support the case for investing in prevention.

Tables 4. & 5. highlight the cost of not acting based on evidenced reviews undertaken on both health outcomes and risk factors.

Table 4. Costs of not acting – health outcomes

Health Topic	DALYs lost in Europe (millions)	Costs to individual	Costs to the health sector	Costs to governments/ wider society
Cardiovascular disease	36.4	-	-	€169 billion per year
Cancer	17.0	-	6.5% of EU health care spending	€117 billion per year
Diabetes	2.6	-	Cost to NHS £1.3 billion per year	-
Mental health	28.9	£11 - £59,000 per child. Complex cases are considered to cost £1000/week (UK)	10.48% of the NHS budget is spent on mental health services. Costs from 2007 figures in the UK £1.7 billion spent on depression, £1.2 billion on anxiety	£110 billion per year in the UK

Table 5. Costs of not acting – risk factors

Health Topic	DALYs lost in Europe (millions)	Costs to individual	Costs to health sector	Costs to governments/wider society
Tobacco	17.7	Average smoker spends the equivalent of two months wages per year on cigarettes	In the UK costs to the NHS are more than £5 billion per year	US\$500 billion per year to the global economy
Harmful alcohol intake	17.3	Risk of unemployment, increased absenteeism or attending work in an unfit state	Cost to NHS per year £2.9 billion	Alcohol related harm costs in the UK £20-55 billion; EU €125 billion per year
Unhealthy nutritional intake	15.3	Health expenditure is increased by 30% for obese individuals compared to those of a healthy weight	Obesity accounts for 0.7 – 2.8% of total health expenditure for most countries	1-3% of GDP in most countries, 5-10% in the USA
Physical inactivity	8.2	Can account for up to 8% of social disability payments	Global inactivity accounts for 1.5-3% of health care budgets	Inactivity estimated to cost Europe €150- 300 per year

Information sources for Tables 4 & 5: World Health Organisation report - The case for investing in public health (2012)

NOTE:

DALYs – disability-adjusted life years = a time based measure combining years of life lost due to Premature mortality and year of life lost due to ill health used to assess global burden of disease

Investing to save - in mental health interventions

While we cannot be sure what the statistics are for our population in the Falkland Islands if we consider an example around mental health from another jurisdiction we can see that there is strong evidence to support the case for investing.

Evidence from the UK indicates that 1 in 4 people will suffer a mental health problem each year. This costs the UK government £19 billion annually however there is evidence to support the case for investment in prevention programmes to save society future costs:

For every £1 invested in mental health interventions results in a saving to society of:

- Workplace wellness programmes £2.37
- Schools based resilience programmes £5.08
- Tackling loneliness in older adults £1.26

Information source: Public Health England

Strengthening Capacity

Developing systems which strengthen the capacity to deliver public health is important to improving population health. Core commonalities across international frameworks have resulted in a structure **Table 3**. which can assist countries to work towards a model of excellence in public health. This model can be drawn upon to allow consideration of where capacity could be strengthened in the Falkland Islands. This would enable us to develop a robust public health system, supporting those services already in place and work well in the current health care system alongside developing new capacity with a public health unit.

Table 3: Framework for Developing Public Health Capacity

Public Health Capacity Building					
Organisational Structures <ul style="list-style-type: none"> • Institutional capacity for public health • Programme delivery structures • Public health aspects of health care service • Capacity to respond to emergencies 	Partnerships <ul style="list-style-type: none"> • Formal and informal partnerships • Joined-up government 	Financial Resources <ul style="list-style-type: none"> • Sustainable financial resourcing 	Workforce <ul style="list-style-type: none"> • Human resources • Training and development • Public health competencies • Professional associations 	Knowledge Development <ul style="list-style-type: none"> • Health information and monitoring systems • Public health reporting • Research and knowledge infrastructures 	Leadership & Governance <ul style="list-style-type: none"> • Responsibilities for public health • Policy making for public health • Expertise in the health sector • Leadership qualities in the health sector

Adapted from Aluttis et al. (2014)

Four areas have been identified here in the Falkland Islands which we must begin to address if we wish to make an impact to establish public health and make improvements for population health:

- Data collection, research and monitoring must commence
- Capacity building in the workforce is critical
- Healthier choices must become the easier option
- A “Health in All Policies” approach needs to be incorporated to ensure healthy working and living environments for this and future generations

These priority areas are outlined below with recommended actions. It is intended that this strategy is a living document which will require frequent reviews and new priorities should be established once these foundational steps have been achieved.

Public Health Strategic Priorities as Next Steps

Strategic Priority 1: Recognise the importance of data collection and research to provide for a robust evidence base and ongoing population monitoring for public health

Objective	Performance Measure	Activities	Time Frame/Review	Primary Lead/Department
Introduce mandatory reporting of health indicator statistics	Statistics reported and tracked	Multi-agency confirmation of key health indicators for annual reporting Creation of a data collection and reporting policy, including political commitment and allocation of sufficient resources	2019-2021	DHSS/PH/Policy/RFIP/Education
Collect and analyse data related to MTOs over the past 5-10 years	Anonymised data reported and analysed	Analyse data to establish numbers and costs related to referral and treatments at a population level	2019-2021	DHSS/PH/Policy
Establish a baseline to indicate if the population is meeting 5-A-Day for vegetables and fruit	Baseline survey results published	Conduct a health and lifestyle survey to develop baseline data	2019	PH
Establish a baseline to indicate proportion of fat, sugar and salt in the daily diet	Baseline survey results published	Conduct a health and lifestyle survey to develop baseline data	2019	PH
Establish a baseline to indicate the proportion of the population who are physically active	Baseline survey results published	Conduct a health and lifestyle survey to develop baseline data Investigate potential measures with activity and sports providers to be able to monitor active participation	2019	PH

Strategic Priority 2: Create a public health unit and develop workforce capacity for public health delivery

Objective	Performance Measure	Activities	Time Frame/Review	Primary Lead/Department(s)
Establish a public health unit	Identify and/or train personnel to delivery sustainable health promotion activities, data collection and analysis	<p>Establish a public health unit with a Head of Public Health</p> <p>Identify staff within FIG currently in post with specialist skills who have capacity for resourcing public health development e.g. data managers, statisticians and health promotion specialists</p> <p>Identify private sector and community services providers who can provide specialist services to build a network of public health service providers</p>	2019-2021	PH/HR/DHSS/DPED
Support staff to maintain continuous professional development (CPD) to aim to strengthen expertise	Develop individual CPD plans for personnel to ensure professional registration compliance	Identify courses and funding to support employee development and maintain professional registration	2019-2021	Line Mangers DHSS/PH

Strategic Priority 3: Support and develop policies that enable the community to be make healthier choices: a healthy diet, be physically active, drink alcohol responsibly and be tobacco free.

Objective	Performance Measure	Activities	Time Frame/Review	Primary Lead/Department
Increase provision of locally grown produce reducing reliance on imports of vegetables and fruit	Number of local producers	Investigate opportunities in collaboration with current and potential producers to identify barriers to increasing production	2019-2021	Collaboration PH/FIDC/local producers
Increase awareness in the community of healthier choice options and decreasing consumption of less healthy alternatives	Sales data Attendance numbers	Develop partnership activities with retailers to mutual benefit to market healthier choices Education workshops to increase consumer knowledge on health topics	2019-2021	Collaboration PH/retail/community
Increase opportunities for physical activity	Number and range of new programmes	Via education and workplace encourage and support walking and biking to school and work Promote current recreation programmes Partnership collaboration to target hard to reach groups Invest in commissioning of services to meet community demand	2019-2021	PH/SLC/FIOGA/voluntary sector
Aim to reduce harmful alcohol consumption	Sales data Import data Census data	Continued commitment to increasing import tax Investigate possibilities with retails to reduce alcohol advertising across multiple media	2019-2021	DHSS/PH/C&I
Increase opportunities for interventions to raise awareness of harmful alcohol consumption	Attendance numbers	Education workshops Collaborative working as the development of the Mental Health Strategy commences	2019-2021	DHSS/PH
Increase the number of government departments that adopt a smoke-free policy (buildings and premises)	Number of new smoke-free departments	Advocate for smoke-free environments Support departments in developing policies that encourage employees to quit	2019-2021	DHSS/PH
Increase the number of individual cessation efforts in the community,	Number of new individuals accessing cessation clinics	Develop sustainable approaches for cessation clinic delivery via dedicated personnel resource	2019-2021	DHSS/PH

working towards a smoke free society		Publicise and promote access to support services Incentive programmes to target hard to reach groups		
Aim to be a smoke free society. Less than 5% smoking prevalence by 2035	Sales data Import data Census data	Continued commitment to increasing import tax Annual monitoring of smoking prevalence Strengthen legislation where appropriate to align with recommendation in WHO's Framework Convention on Tobacco Control (FCTC)	2019-2021	DHSS/PH/C&I AGs

Note: Some resources to support education/community awareness campaigns can potentially be accessed free of charge via established contacts with Public Health England and the Health Promotion Agency in New Zealand.

Strategic Priority 4: Support and develop services and policies that emphasis wellbeing environments which can reduce the healthcare burden in the long term

Objective	Performance Measure	Activities	Time Frame	Lead/Department
Incorporate health impact assessments (HIA) into infrastructure and planning development	Number of HIAs completed	<p>Develop a Falklands appropriate HIA</p> <p>Advocate for HIAs to be undertaken for planning and policy implementation to ensure evaluation of potential health impacts is considered</p> <p>Advocate for maintaining and inclusion of green space in new development</p> <p>Advocate for facilitation of active transportation in new development</p>	2019- 2021	Planning/PWD/PH
Establish collaborative organisational and community partnerships whose activities work towards improved wellbeing for the community	Number of partnerships	<p>Develop and build relationships of mutual benefit with the private and voluntary sector</p> <p>Seek out opportunities for collaborative engagement which embed the notion that disease prevention is everyone's business</p>	2019-2021	Across sectors/collaboration with partners
Incorporate wellbeing at work initiatives across government and advocate for the private sector to implement	Number of departments/businesses implementing wellbeing into the workplace	Staff involvement from each Directorate to develop activities that fit the workforce	2019-2021	PH/collaboration with departments and partners

Conclusion

The current absence of data creates a challenge for accurately assessing population health in the Falkland Islands.

There is a clear need to ensure that data is collected, analysed and tracked to be able to gather a complete picture of population health status and to be able to understand what drives health outcomes, along with identifying where improvements can be made over time.

Emphasising a shared responsibility for health is now an established practice in health promotion so developing strong collaborations with partners and fostering community engagement will be important to making improvements for the entire community.

A public health unit, sustainably resourced to build the foundations required to improve public health provision in the Falkland Islands, does have the potential to contribute to achieving The Islands Plan 2018-2022 vision of supporting everyone in the community to enjoy a healthy lifestyle.

References

- Aluttis, C. et al. (2014) *Public health and health promotion capacity at national and regional level: A review of conceptual frameworks*. Journal of Public Health Research. 3 (199), 37 – 42.
- Buck, D., Baylis, A., Dougall, D. & Robertson, R. (2018). *A vision for population health. Towards a healthier future*. The King's Fund, London, England.
- Dahlgren, G. & Whitehead, M. (1991). *Policies and Strategies to Promote Social Equity in Health*. Institute for Futures Studies, Stockholm, Sweden.
- DEFRA (2013). *Sustainable Development Indicators*. Crown copyright, London, United Kingdom.
- Department of Health (2010). Local Government Improvement and Development. *Not Another Consultation! Making Community Engagement Informal and Fun*. London, United Kingdom.
- Department of Health (2012). *Report. Long-term conditions compendium of Information: 3rd edition*
- Department of Health (2014). *Wellbeing. Why it matters to health policy. Health is the top thing people say matters to their wellbeing*.
- Department of Health (2016). *Improving outcomes and supporting transparency. Part 2: Summary technical specifications of public health indicators*. Crown copyright, London, United Kingdom.
- Diggle, R. (2000). *Health of the Nation*. Falkland Islands Government.
- Diggle, R. (2003). *Medicine in the Falkland Islands*. BMJ, Postgraduate Medical Journal. 79, 3-4.
- Falkland Islands Government. (2002). *The Tooth Report. An oral health strategy for the Falkland Islands*. Falkland Islands Government, Stanley.
- Falkland Islands Government (2012). *Census report*. Falkland Islands Government, Secretariat, Stanley.
- Falkland Islands Government (2015). *Statistical Year Book 2014*. Falkland Islands Government, Secretariat, Stanley.
- Falkland Islands Government (2016). *Census report*. Falkland Islands Government, Secretariat, Stanley.
- Falkland Islands Government. (2017). *The Islands Plan 2018 – 2022*. Falkland Islands Government, Gilbert House, Stanley.
- Faculty of Public Health. (2016). *Good public health practice framework*. London, UK.
- Finlayson, K.E., Dryden, M. & Smedley, S. (2018). *Implementation of home-based specimen collection for sexual health screening in the Falkland Islands: The impacts on user groups and healthcare provision*. Unpublished MSc paper.
- Jones, C.M. & Walters, B. (2015). *Dental survey in the Falkland Islands' child population*. Community Dental Health. 32, 190 – 192.

- Jones, C.M. (2018). *Falkland Islands oral health strategy for 2018 – 2028 (Draft version 2)*.
- King, H.O.M. & Bleaney, A.A. (1982). *The Falkland Islands morbidity survey*. Journal of the Royal College of General Practitioners. 32, 535 – 546.
- King, H.O.M. & Bleaney, A.A. (1984). *The low prevalence of hypertension in the Falkland Islands men*. Journal of the Royal College of General Practitioners. 34, 95 - 96.
- Local Government Association. (2016). *Health in All Policies. A manual for local government*. London, England.
- Ministry of Health. (2006). *A Guide to Developing Public Health Programmes: A generic programme logic model. Occasional Bulletin No. 35*. Wellington, New Zealand.
- Public Health England (2017). *Health and well-being in rural areas*. Crown copyright, London, England.
- Public Health England (2017). *Making obesity everybody's business*. Crown copyright, London, England.
- Public Health England (2017). *Workplace health needs assessment. How to use the assessment and HNA questions*. Crown copyright, London, England.
- Public Health England (2018). *Improving people's health: applying behavioural and social sciences to improve population health and wellbeing in England*. Crown copyright, London, England.
- Rimicans K. & McInery, T. (2018). *52 degrees south: mental health services in the Falkland Islands*. BJPSYCH International, 15 (2), 30 – 32.
- Schools Health Education Unit. (2011). *Young People in South Atlantic Overseas Territories. The Health-Related Behaviour Survey 2011. A Report for the Falkland Islands Community School*. Exeter, United Kingdom.
- Swerdlow, A.J., Elsby, B. & Qiao, Z. (2001). *Cancer incidence in the Falkland Islands*. British Journal of Cancer, 85 (9), 1332 – 1334.
- World Health Organisation. (2005) *WHO Framework Convention on Tobacco Control*. Geneva, Switzerland.
- World Health Organisation. (2012). *The Case for Investing in Public Health*. Regional Office for Europe, Denmark.
- World Health Organisation. (2012). *European Action Plan for Strengthening Public Health Capacities and Services*. Geneva, Switzerland.
- World Health Organisation. (2016). *Fiscal Policies for Diet and Prevention of Non-communicable Diseases*. Geneva, Switzerland.
- World Health Organisation. (2017). *Tackling NCDs*. Geneva, Switzerland.