EVIDENCE TO DHSSPS HEALTH COMMITTEE
INQUIRY ON OBESITY

February 2009

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1. Introduction

1.1 The prevalence of obesity has increased dramatically over the past few decades throughout the UK and in many other Western countries. Staying a healthy weight, eating sensibly and keeping active can improve health and reduce the risk of diseases associated with being overweight, such as coronary heart disease, osteoporosis, cancer and type two diabetes.

1.2 The obesity related conditions outlined above reduce life expectancy, undermine quality of life, and impose huge burdens on families, carers and health services. Investing resources in addressing obesity should provide value for money for Government at all levels. If levels of obesity continue to rise unabated it is very likely that the related costs will grow significantly over the next few decades.

Obesity Definition

1.3 Obesity is a condition where weight gain has got to the point that it poses a serious threat to health. Obesity is usually measured by Body Mass Index (BMI), which is a function of person’s height and weight. In adults having a BMI of 25-30 is classified as being overweight and having a BMI of 30 or more is classified as obese. For children special reference curves have been designed to calculate BMI as the height and weight of children varies with age and gender.

1.4 However, BMI should only be considered as an approximate guide to overweight and obesity because it may not correspond to the same level of fat in different individuals. For example, differences in distribution of fat around the body, higher or lower than average amounts of muscle, and ethnic differences may mean that people with

the same BMI have different levels of fat, and this may affect the associated health risks.

Impact of Obesity

1.5 Research has indicated that being obese may increase the risk of the following health conditions:

- heart disease and stroke;
- type 2 diabetes
- some cancers, including post menopausal breast cancer;
- hypertension;
- gall bladder disease;
- osteoarthritis;
- sleep apnoea;
- breathing problems;
- lower back pain; and
- complications in pregnancy.

1.6 Evidence also indicates that obesity:

- can reduce life expectancy by approximately 9 years; and
- can impact on emotional/psychological well-being and self-esteem, especially among young people.

Prevalence of Obesity in Northern Ireland

Adults

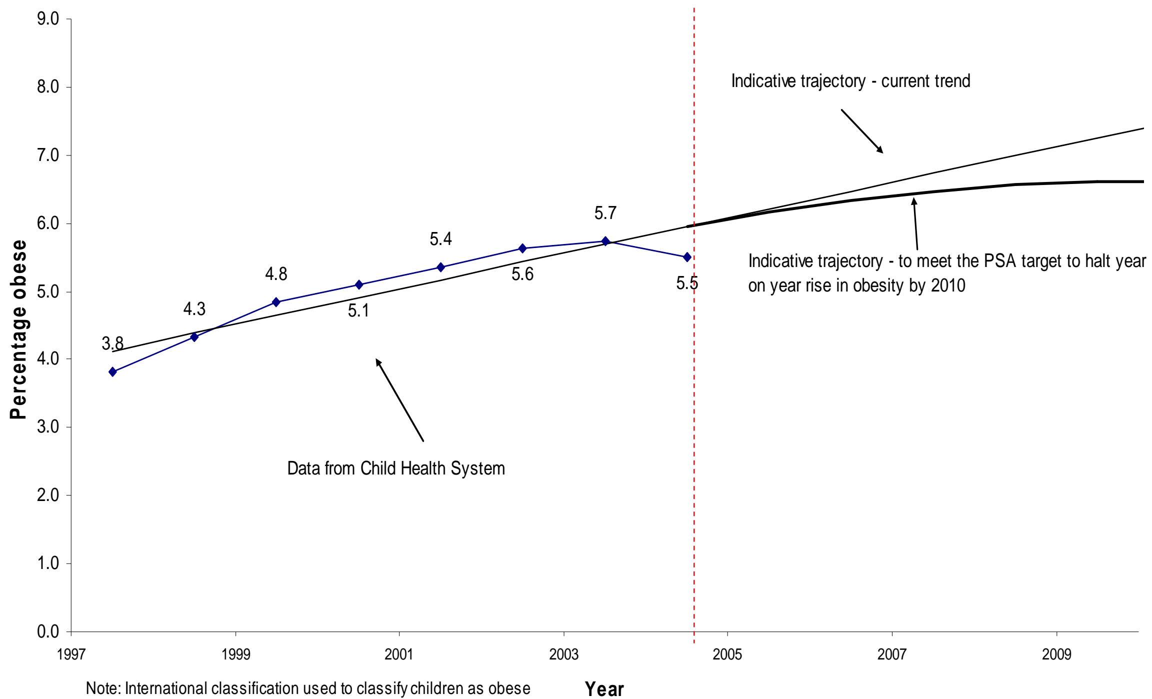
1.7 The 2005 Northern Ireland Health and Social Wellbeing Survey (HSWB) found that overall 59% of all adults measured were either overweight (35%) or obese (24%). The 2005 Survey also reported that 64% of adult males and 54% of adult females were either overweight or obese (compared to 63% and 50% for men and women respectively in the 1997 survey). By comparison the Scottish Health Survey 2003 also recorded Scotland at 24%. The National Audit

Office in their report: Tackling Obesity in England, recorded adult obesity prevalence in England at 23% and

Children & Young People

1.8 The position is also particularly worrying among our children and young people. Data from the NI Child Health System indicate that in 1997/98, based on measurements carried out during the primary one health appraisal, approx 4% of children aged around 5 were found to be obese with 17% classified as being overweight or obese. In 2004/05 more than 5% of children were obese with 22% classified as being overweight or obese. Using this data it has been projected that without significant intervention just over 7% of children aged around 5 will be obese and almost 27% will be overweight or obese by 2010.

1.9 The following graph sets out the percentage of children in Northern Ireland aged 4 ½ to 5 ½ classified as either overweight or obese, using the international approach, from 1997-98 to 2005-06.



Aetiology of Obesity

1.10 Obesity occurs when an individual takes in more energy through the food and drink they consume than they expend through natural bodily processes and physical activity. The direct cause of obesity is, therefore, an energy imbalance. However, it doesn't take much to tip the balance. It has been estimated that an average adult whose daily energy intake is just 60 calories more than their energy output will become obese within ten years.

1.11 It is less clear, however, which factors contribute most to tipping the energy balance. In terms of the intake side of the equation, people don't appear to be taking in more calories, but our current diet contains too much fat and sugar. Eating high fat, energy dense foods can create an overeating effect and contribute to obesity. It is also recognised that evolving eating patterns has a key role to play, for

example, there is more snacking and greater dependence on prepared foods.

1.12 In relation to energy use, people today are undoubtedly less active than previous generations and low levels of activity contribute to obesity. The National Audit Office has previously estimated that the extra physical activity involved in daily living 50 years ago, compared with today was equivalent to running a marathon a week.

Obesogenic Environment

1.13 It may seem simplistic that an individual is solely responsible for their weight gain, however research has shown that a very complex range of factors is involved – from biology, through to the built environment, to the advertising people are exposed to everyday. It is therefore unclear the extent to which many individuals are able to make genuine choices.

1.14 Increasingly it has been acknowledged that the causes of obesity are associated with a wide range of inter-related factors, from the physical, socio-economic and cultural environment, which act to promote calorie intake and discourage physical activity. These factors are referred to collectively as the "Obesogenic" environment.

1.15 Several hypotheses have been put forward to explain the increase intake of energy, including:

- increased portion sizes;
- increased energy density of food;
- increased availability of 'fast foods'; and
- over-advertisement of energy dense foods.

1.16 There are also a range of hypotheses to explain environments that are less conducive to energy expenditure, including:

- mechanisation of tasks which previously required manual labour;
- concerns over the safety of children and an increased perception of risk leading to reductions in outdoor play and physically strenuous games;
- labour-saving devices; and
- sedentary entertainment.

Cost of Obesity

1.17 Across the UK obesity rates have tripled over the last twenty years. A House of Commons Health Committee Report (2003-04) estimates the cost of obesity at £3.7bn per year. Alternatively, the Foresight Report on Obesity estimated that the NHS costs attributable to overweight and obesity projected to double to £10 billion per year by 2050. The wider costs to society and business are estimated to reach £49.9 billion per year (at today's prices).

1.18 It has been estimated that in Northern Ireland obesity is resulting in 260,000 working days lost each year and is costing the economy approximately £500 million.

1.19 The Northern Ireland Clinical Resource Efficiency Support Team (CREST) on managing obesity also estimated that just stopping the year-on-year increase in levels of obesity would save the Department £210 million over the next twenty years (June 2005).

1.20 The recent Northern Ireland Audit Office report refers to a number of the consequences of obesity and diabetes. It reports that the treatment of those suffering from diabetes is reckoned to cost the health services across the UK around £1 million every hour.

2. Obesity Prevention Policy

Policy Background

2.1 The Northern Ireland Assembly's Programme for Government identified working for a healthier people as one of five overarching priorities. Investing for Health (IfH), published in March 2002, is Northern Ireland's Public Health Strategy, and it sets out how these commitments are to be met. The strategy outlines the approach to improving health and wellbeing, reducing health inequalities and also provides a framework for efforts to achieve this commitment.

2.2 Even before the publication of IfH, the Department of Health, Social Services, and Public Safety had recognised the relationship between a healthy diet, physical activity and good health, especially in respect of Coronary Heart Disease. For example these issues were key elements in the "Change of Heart" programme that operated in the 1980s and 1990s. Subsequently work was undertaken to develop separate food and nutrition and physical activity strategies. However, more recently there has been a greater acceptance of the need to develop an integrated approach to obesity.

2.3 The Ministerial Group on Public Health (MGPH), which oversees the ongoing policy development and implementation of IfH, became particularly concerned about the quickly rising levels of obesity in Northern Ireland – especially among children and young people. Therefore in 2004 MGPH established the Fit Futures Taskforce to examine options for preventing overweight and obesity in children and young people, and to make recommendations for integrated, cross-Departmental Action to MGPH.

Development of Fit Futures

2.4 To take forward this work, the Fit Futures Taskforce initiated wide-ranging research and engagement processes. To develop the evidence base for the recommendations the research aspect included:

- developing a local research and information baseline;
- conducting a review of the international evidence base; and
- carrying out comparative research, including looking at approaches in other countries.

2.5 In addition, a number of consultation and engagement events and workshops were held with key stakeholders, including young people and their parents. At the same time literature and desk reviews were commissioned which looked at the current evidence base relating to prevention and good practice. A particular focus was placed on looking at effective policies and programmes that were currently in operation.

Summary of the Fit Futures Report

2.6 The final report of the Fit Futures Taskforce was published in 2006; it identified a number of priority approaches and made over 70 recommendations for action.

2.7 The Key Principals of Fit Futures are set out below:

- providing leadership and leading by example;
- building on existing good practice;
- adopting an holistic and long-term approach;
- focussing on environmental and lifestyle factors;
- taking account of key motivating factors;
- being positive and encouraging to help young people develop a sense of self esteem and self worth;
- adopting a population approach;

- reflecting the importance of early years and the significant role of parents and carers;
- ensuring Schools fulfil a key role;
- recognising the importance of basic knowledge and skills in the community; and
- being evidence based.

2.8 One of the key points made by the report was the recognition that, given the obesogenic environment, the Department of Health, Social Services and Public Safety (DHSSPS) could not effectively address this issue on its own. It therefore contained a joint target, between DHSSPS, the Department of Education (DE), and the Department of Culture, Arts and Leisure (DCAL), "to halt the rise in obesity in children by 2010".

Fit Futures Implementation Plan

2.9 Based on the responses to the Fit Futures report, an Implementation Plan was developed and published for consultation in February 2007. This consultation process was used to inform further policy development on this issue. Following the consultation period full consideration was given to comments received and to the emerging policy environment.

2.10 Shortly after the publication of the implementation plan, strategic and policy developments from elsewhere reinforced the need to develop a **whole population** approach to the issue. This was particularly informed by the "Foresight" report (see paragraphs 2.16-2.19) which was launched in October 2007.

2.11 Reflecting on these developments, the Department decided to integrate Fit Futures into the development of a broad strategic

framework to address obesity across the life course. Therefore, while this implementation report was not formally published by the Department, progress has been, and continues to be, made to deliver on its recommendations and actions at both the regional and local level.

2.12 Although the strategic emphasis is currently on developing an integrated obesity framework, the Department does recognise the need to incorporate elements relating to physical activity and food and nutrition. At this stage, therefore, the Department is not planning to develop separate strategies for these areas, but it will ensure that they are fully incorporated into the overarching framework, and that relevant outcomes and outputs are developed in relation to physical activity and food and nutrition. Meanwhile, the Department has established a process to oversee the delivery of Fit Futures and develop a life course approach to preventing obesity (see **Section 3**).

Funding

2.13 DHSSPS allocated £832,000 to the implementation of Fit Futures in 08/09. In addition, a further £550,000 and £300,000 has been allocated for work around promoting physical activity and improving food and nutrition respectively.

Local Delivery

2.14 Much of the funding set out in paragraph 2.13 has been allocated to the local Health and Social Services Boards to deliver local actions, activities and programmes aimed at meeting the needs of their local populations and helping to prevent obesity.

2.15 As part of Fit Futures, the Investing for Health Partnerships in each Board area were tasked under a Priorities for Action target to develop

and deliver local integrated Fit Futures Plans. This work continues to be taken forward at a local level.

Obesity Policy Developments

2.16 In 2005, the Westminster Government commissioned Foresight to carry out a systematic review of obesity. Foresight reported its findings 'Tackling Obesities: Future Choices' Project in October 2007 – and this has informed local policy development and the Department's decision to undertake a life course approach to preventing obesity.

2.17 Foresight is the Westminster Government's science futures think tank based in the Government Office for Science. The aim of the programme is to build on the scientific evidence base to provide challenging visions of the future to help inform government strategies, policies and priorities.

2.18 The UK wide project looked at how to respond sustainably to the prevalence of obesity in the UK over the next 40 years, and its key findings include:

- most adults in the UK are already overweight. Modern living ensures every generation is heavier than the last – `Passive Obesity';
- by 2050 60% of men and 50% of women could be clinically obese. Without action, obesity-related diseases will cost an extra £45.5 billion per year;
- the obesity epidemic cannot be prevented by individual action alone and demands a societal approach;
- tackling obesity requires far greater change than anything tried so far, and at multiple levels: personal, family, community and national; and

- preventing obesity is a societal challenge, similar to climate change. It requires partnership between government, science, business and civil society.

2.19 A copy of the 'Tackling Obesities: Future Choices' Foresight Project is available on Foresight's website at: http://www.foresight.gov.uk/.

England

2.20 England published their cross-Government Strategy, "Healthy Weight, Healthy Lives" in January 2008 and can be found at; www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082378.

Scotland

2.21 In June 2008 Scotland published an action programme covering healthy eating, physical activity and healthy weight called Healthy Eating, Active Living: An action plan to improve diet, increase physical activity and tackle obesity (2008-2011) which can be found at www.scotland.gov.uk/Publications/2008/06/20155902/0.

2.22 This builds on, rather than replaces, the existing delivery of the Physical Activity Strategy and Diet Action Plan. The strategic spending review 2007 has committed an additional £40 million over the next three years to delivering in these three interlinked policy areas.

Wales

2.23 On 29 June 2006 the Food and Fitness Implementation Plan for Children and Young People was launched by the Welsh Assembly. This can be found at

http://wales.gov.uk/topics/health/improvement/food/food-fitness/plan/?lang=en.

2.24 A new Welsh Assembly Government-funded programme designed to help overweight and obese children manage their weight and become fitter, healthier and happier was rolled out across Wales from 20 January 2009. The £1.4 million scheme will target around 2,000 children aged between 7-13 years old and their families over the next three years.

Wider Europe

2.25 These developments also informed our thinking on this issue, along with a range of other policy developments across a range of European countries (A paper by WHO Europe entitles “Nutrition, Physical Activity and Prevention of Obesity: Recent Policy Developments in the WHO European Region” – provides a very useful summary of these developments and can be found at www.euro.who.int/Document/NUT/Instanbul_conf_ebd07.pdf.

3. Developing a Life Course Approach

Obesity Prevention Steering Group

3.1 To oversee the progress against the Fit Futures recommendations, and lead the development of an overarching policy to prevent obesity across the life course, the Department established the cross-sectoral Obesity Prevention Steering Group (OPSG) in February 2008. In recognition of the emerging policy consensus that acknowledges that obesity is an issue the DHSSPS cannot effectively address on its own, the OPSG also contains a strong representation from other local Government Departments, particularly DE, DCAL, Department of Regional Development (DRD), Department of Social Development (DSD), and Department of Agriculture and Rural Development (DARD). The membership of the steering group and its Terms of Reference are set out at **Annex A**.

Advisory Groups

3.2 In recognition of the wide range of areas and issues that form the obesity context, four policy advisory sub-groups have been established to support the work of the OPSG. This approach also acknowledges the particular role that food and nutrition and physical activity must play in addressing obesity. These groups, which have similar terms of reference to the OPSG, are:

- the Food and Nutrition Advisory Group;
- the Promoting Physical Activity Advisory Group;
- the Education, Prevention and Public Information Advisory Group; and
- the Data and Research Advisory Group.

3.3 As an initial step, each Advisory Group, whose membership is set out in **Annex B**, considered the appropriateness of their terms of

reference and sought to identify additional members who would be essential in taking forward this work.

3.4 Following initial discussion the Advisory Groups considered the progress to date against the outcomes in Fit Futures, and set out any future plans to address these. Subsequently the groups have been considering the ongoing appropriateness of these actions aimed at addressing childhood obesity and have begun to revise them in order to form the early years, and children and young people sections of an overarching obesity prevention framework. This will ensure that the good work taken forward under Fit Futures is not lost within the life course approach and will instead be used to inform and lead the development of this policy.

Obesity Strategic Framework

3.5 The next step is for the OPSG, and the Advisory Groups, to look forward and decide what outcomes they would like to see achieved in the next 5 and 10 years. This forward looking piece of work will allow the development of a range of short, medium, and long term outcomes and actions using the logic model approach (see **Annex D** for further information).

3.6 It is anticipated that this development process will take place over the next financial year. However, this work will not prevent action on this issue in the interim. Work will continue on delivering on the revised Fit Futures recommendations, and on programmes aimed at preventing obesity in the adult population.

North/South/East/West

3.7 It is clear that this is an issue that is facing much of western society and not just Northern Ireland. In particular, we are keen to learn from

and build on the work taken forward within the other UK jurisdictions. To this end, an informal four nation, Information sharing sub-group has been established. This has allowed us to build relationships and knowledge in this area, and learn from good practice and research undertaken elsewhere.

3.8 We also recognise that this is an issue facing Ireland, and we continue to build our relationship with our colleagues there. Outcomes from this cooperation include an all-Island obesity conference held in Belfast on 13-14 November 2008, the running of the "Little Steps, Go a Long Way" campaign developed by Safefood across the island, and the establishment of an all-island Obesity Observatory.

3.9 It is anticipated that the links that have been developed will be used to inform the development process. It will also provide the opportunity, where appropriate, to take forward work on a joined up consistent basic and potentially allow us to gain again from economy of scale.

4. Obesity Treatment

Primary Care

4.1 Primary Care has an important role in the identification, assessment and management of obesity. Obesity Management is integral to the management of other conditions such as coronary heart disease, stroke, atrial fibrillation and diabetes.

Investments in primary care

4.2 The 2004 General Medical Services contract brought significant investment in General Medical Services (GMS) in Northern Ireland. The size, scale and scope of the investment in primary care, together with the incentives for practices to improve the quality and outcomes in treating acute and chronic health problems, facilitated the concentration of General Practitioners and their staff on the delivery of high quality primary care. GMS funding flows via three main funding streams, Global Sum, Enhanced Services and the quality of care to patients across a range of common chronic diseases through the Quality and Outcomes Framework (QOF).

Quality and Outcomes Framework (QOF)

4.3 QOF is a fundamental part of the GMS Contract; it remunerates GP practices for providing good quality care to their patients and it helps to fund work to improve further the quality of care provided.

4.4 Clinical standards is one of the four main components of the quality framework. Since April 2006, the QOF has included an indicator for practices to set up a register of patients aged 16 and over who have a Body Mass Index (BMI) equal to or greater than 30kg/m2. The extension of the existing QOF indictor on obesity was to encourage practices, by way of an incentive, to provide interventions, that would,

based upon the best available evidence and recommendations by the National Institute for Clinical Excellence (NICE), reduce the prevalence and severity of conditions linked to obesity.

Directed Enhanced Service (DES)

4.5 Further, by way of a Directed Enhanced Service (DES), since 2006, additional funding approximately £800k has been provided to build on the capacity of practices to play an important role in the service provision for early detection and provision of necessary follow-up of patients who have a BMI of 30kg/m2 who are likely to develop morbidity such as diabetes mellitus. The service is directed at helping those patients with obesity with or without other co-morbidities.

4.6 In relation to this DES practices are required to develop a written protocol for such patients, that includes:

- the frequency of repeat weight measurement, testing for blood lipids and glucose;
- if the service is available, the physical activity referral process;
- criteria for anti-obesity drug treatment;
- description of the contents of the practice resource kit available to such patients; and
- description of the follow-up protocols for such patients, including routine blood pressure monitoring and thyroid function tests;
- undertakes to offer, for those patients who smoke, referral to local specialist smoking cessation services and provide all relevant information to motivated patients;
- undertakes to offer and record an annual follow-up treatment plan for those patients identified with lipid or glucose abnormalities, e.g. impaired glucose tolerance; and

- a requirement that the contractor (practice) develop a practice resource kit for, and provides such a kit to motivated patients with a BMI greater than 30 who are likely to develop morbidity such as diabetes mellitus;

4.7 In addition, there is a requirement for practices to ensure that any health care professional who is involved in the management and treatment of patients has the necessary experience, skills and training with regard to the identification and treatment of patients with a BMI greater than 30 who are likely to develop morbidity such as diabetes mellitus, and training needs in relation to those areas outlined are regularly reviewed.

4.8 Full details of the service description relating to this DES can be found at: http://www.dhsspsni.gov.uk/index/hss/gp_contracts/gp_contract_directions.htm.

Current status in Northern Ireland

4.9 All the practices in Northern Ireland have participated in the QOF since its introduction in April 2004. In relation to co-morbidities areas the achievement points were in the range of 99% to 99.8%. The 2007/08 QOF achievement figures by practices in Northern Ireland illustrate the commitment of GPS quality patient care. Furthermore Practices achieved the maximum points available in relation to the DES relating to obesity

4.10 The Department has continued to offer incentives to primary care practitioners to enhance and develop their services through the QOF and the DES initiatives. In 2009, the treatment of mild to moderate depression was included as a DES. Whilst this DES is not directly

linked to the treatment of obesity it is generally recognised, although not in all cases, that there are psychological consequences of obesity such as lower self esteem or social isolation. By assessing patients who suffer from mild to moderate depression it may be possible to establish that their depression is linked to low self esteem as a result of obesity and appropriate intervention may be offered to address both conditions.

4.11 Although there is no data currently available to demonstrate the cost effectiveness of primary care interventions as a result of the incentives provided through the QOF and the DES initiatives, evidence suggests that even a modest weight loss of 5-10 % of body weight in an obese person can result in health and well-being benefits and thus should result in cost savings in health care.

4.12 Finally, the Department continues to look for opportunities within the GMS contract to address obesity issues. However, as the contract is UK wide areas identified will have to be agreed across the 4 UK Health Departments before they can be implemented.

Secondary Care

4.13 However, it is recognised that the problem of obesity cannot be addressed through primary care management alone. While services may be mainly primary care-based they interface with secondary care in many ways. The growing epidemic of obesity has practical implications for hospital services in terms of transport, accommodation and equipment to manage increasingly heavy patients as well as the increasing pressure on services due to the adverse impact that being overweight/obese has on people's health.

4.14 Patients with significant weight management/obesity issues which may be directly or indirectly linked to their condition are seen and treated in almost every service within secondary care. These include diabetes, cardiology, respiratory (e.g. sleep apnoea), rheumatology, cancer care, surgery, maternity, infertility and mental health. Historically it has been the presenting condition that is treated and managed, although obesity issues may be one of a number of contributing factors in the development of the disease/condition.

4.15 Health and Social Care Trusts are taking steps to address the challenges presented for secondary care services by the growing numbers of patients who are significantly overweight or obese. For example:

- education programmes for diabetes which inform people about diet, nutrition and exercise as part of lifestyle advice and self management of their condition, are held in both primary and secondary care settings;
- patients for whom surgery is planned will receive general advice in relation to good diet, BMI at day surgery pre-assessment and referral to dietician if appropriate. Pre-operative assessment will include advice on weight loss as part of the patient's pathway to recovery; and,
- weight management advice is offered to patients who may have established cardiovascular risk or are waiting for cardiac surgery. Patients may also be referred to initiatives which provide physical activity support.

4.16 Nutrition and Dietetic Services can provide proactive services for patients with weight management or obesity issues across the range of secondary care hospital based services. Referrals of inpatients are normally made at the consultant's discretion and the dietetic service

can provide advice and guidance with diet and lifestyle. Outpatient referrals may also be made to dietetics in relation to patients with co-morbidities such as diabetes, cardiology, cardiac rehabilitation programmes, surgery and general medicine.

4.17 It is recognised, however, that specialist supporting dietetic services need to be further developed to meet current and anticipated future demands. There will need to be additional staff, primarily dieticians and nurses, and training/specialist knowledge enhanced in secondary care. All this will require investment, and will need to be considered in light of other competing priorities for health and social care funding.

Bariatric Surgery

4.18 The management of obesity can be challenging, and patients for whom a dietary approach has been unsuccessful, surgery (usually referred to as bariatric surgery) may be considered. Bariatric surgery is the term used to describe a range of surgical procedures which are carried out to modify the gastrointestinal tract to reduce the intake and/or absorption of food. There are two main types of bariatric surgery:

- **Restrictive** – where the size of the stomach is restricted so the person feels full with less food. Restrictive procedures include gastroplasty and gastric banding;
- **Malabsorptive** – where parts of the gastrointestinal tract are bypassed to limit the absorption of food. Malabsorptive procedures include jejunoileal bypass, gastric bypass and biliopancreatic diversion.

4.19 Surgical management is complex and involves not just the surgical operation but extensive care and support from a range of professionals both before surgery and on an ongoing basis after the

operation. A patient will need multidisciplinary team assessment to consider if there are underlying medical conditions which need treatment; exclude serous psychological problems which could result in poor outcomes; and confirm they understand the benefits and risks of the surgery, as well as their ability to adhere to the long-term dietary changes needed if surgery is to be successful. Dietary management after surgery may require specialised support to avoid serious complications.

NICE Guidelines

4.20 On 22 October 2008, the Department issued a circular endorsing a National Institute for Health and Clinical Excellence (NICE) clinical guideline on obesity as applicable to Northern Ireland. NICE clinical guidelines are not mandatory and are endorsed as developmental standards. The HSC is expected to take account of the guidelines in their future planning and delivery of services to patients who are obese or overweight; however in determining their priorities for service development, commissioners must take into account local circumstances, the strategic objectives established for the HSC and competing demands and pressures for a wide range of health and social care services generally.

4.21 The NICE guideline recommends that bariatric surgery to aid weight loss should be available to patients meeting certain body mass index (BMI) criteria. Commissioners have estimated that there are more than 50,000 people in NI who could be eligible using these criteria. Although NICE estimates that only 2-4% of these people would come forward for surgery, this is by no means certain. The cost of treating only 2% of the eligible population and providing the necessary life-long follow-up would be in the order of £20 million. If more people come forward, the cost would rise pro-rata.

4.22 A comprehensive bariatric surgery service is not available in Northern Ireland at present. To date arrangements have been put in place for over 120 patients from Northern Ireland to have bariatric surgery in specialist units in England. Lifelong follow up is being arranged locally. £1.5 million has been set aside for the provision of bariatric surgery in the 2008/09 financial year.

4.23 Commissioners are considering options for the commissioning of a bariatric service, including appropriate pre- and post-operative care and ongoing dietary support. The current position is that they are developing a plan to enable patients who stand to benefit most from bariatric surgery to access it. It is anticipated that these arrangements will be put in place for the 2009-10 financial year.

5. Summary

5.1 The prevalence of obesity in Northern Ireland presents a major challenge, not just for medicine and public health but for governance and decision making. The deceptively simple issue of encouraging physical activity and modifying dietary habits, in reality, raises complex social and economic questions about the need to perhaps reshape public policy in food production, food manufacturing, healthcare, retail, education, culture and trade.

5.2 There are many and varied contributors to the obesity problem and these are societal as well as individual responsibilities. This idea suggests that understanding and tackling the obesogenic environment is necessary to complement school and family-based interventions.

5.3 There are opportunities for Northern Ireland to take a leading role in this worldwide problem by developing and implementing a cross-cutting, comprehensive, long-term strategy that brings together multiple stakeholders. The Department through its development of an Obesity Prevention Strategic Framework is determined to take on this challenge. The Department also has to face the challenge of treating those who present to the health service. These are not issues that will be solved overnight but will take a structured approach over time.

ANNEXES

Annex A – Terms of Reference and Membership of the Obesity Prevention Taskforce Steering Group

Annex B – Membership of Advisory Groups

Annex C – Links to Key Documents and Information

Annex D – Logic Model

Annex A

Obesity Prevention Steering Group Terms of Reference

Chair: Professor Ian Young QUB

Role: The Obesity Prevention Steering Group will oversee, co-ordinate and drive forward the implementation of Fit Futures, and to agree the way forward to prevent obesity in the adult population. The Steering Group will provide relevant advice but will not be directly responsible for the allocation of funding.

Secretariat: DHSSPS Health Development Policy Branch

Primary Functions

- To facilitate and oversee the implementation of the recommendations and various actions within Fit Futures.
- To drive forward the implementation of Fit Futures by providing strong and visible leadership.
- To provide advice and strategic direction on all relevant issues relating to obesity, including the development of an approach to tackle obesity in the adult population.
- To consider the need for additional resources to assist effective implementation and monitoring of Fit Futures.
- To monitor progress against targets and produce a report on progress on implementation for the Ministerial Group on Public Health at the end of year one.

Performance Management Arrangements

- To develop appropriate data collection arrangements in order to allow for monitoring of progress.
- To develop a mechanism for regular reporting to the steering group by relevant organisations.

- To identify barriers to progress, and subsequently feedback relevant issues and possible solutions to MGPH and other relevant organisations.
- To publicise progress were appropriate.

Membership:

Membership of the Obesity Prevention Steering Group will be drawn from as wide a range of organisations as possible, including the statutory sector and voluntary/community organisations.

Those steering group members representing the statutory sector must:

- work at a senior level in their organisation and be able to report on progress;
- have overall responsibility for this area within their organisation; and
- have access to the most senior levels in their organisations.

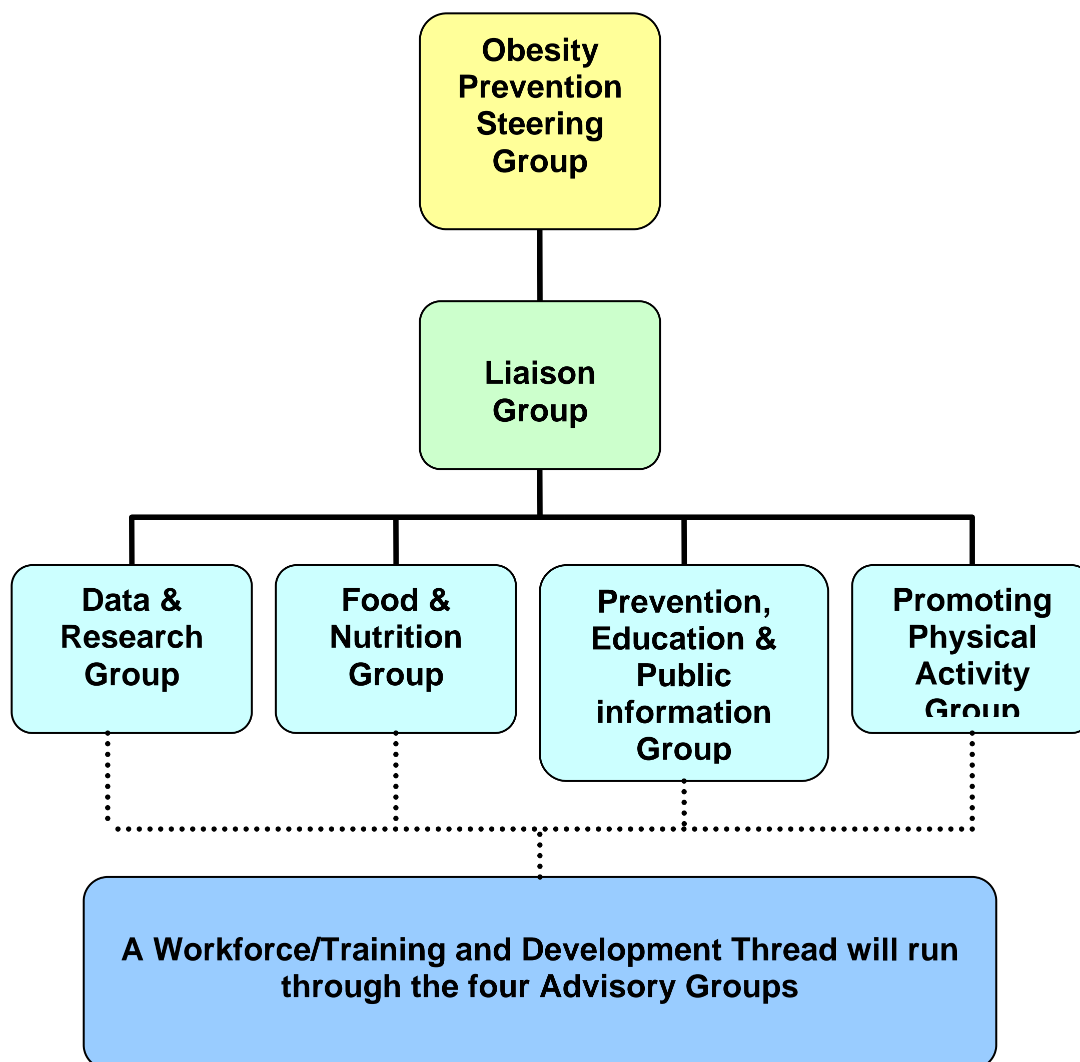
Those steering group members representing the voluntary/community sector must:

- be able to demonstrate an intimate knowledge of community based obesity prevention initiatives; and
- be able to offer considered opinion on a broad range of obesity related matters; and

be able to provide feedback on the work of the steering to the wider community network.

Annex A

Advisory Groups and Reporting Structure



Annex A

Membership of Obesity Prevention Steering Group and Advisory Groups

OBESITY PREVENTION STEERING GROUP MEMBERSHIP

Prof. Ian Young	–	Queens University Belfast (CHAIR)
Andrew Dougal	–	NICHSA
Andrew Elliott	–	DHSSPS
Andy Bready	–	DRD
Angela McComb	–	HPA
Anne Madden	–	NICHSA
Brendan Bonner	–	WHSSB
Ciaran Mee	–	DCAL
Claire Wright	–	DHSSPS
Dr Michael McBride	–	DHSSPS
Dr Naresh Chada	–	DHSSPS
Gary Maxwell	–	DHSSPS
Gerry Bleakney	–	EHSSB
Hilary Johnston	–	NHSSB
Iain Foster	–	Diabetes UK
Ian McClure	–	DHSSPS
Jacqueline O'Loughlin	–	Playboard
John News	–	Sport NI
Lynn Donnelly	–	SHSSB
Lynne Smart	–	SHSCT
Maria Jennings	–	FSANI
Marian Faughnan	–	Safefood Ireland
Martina McNulty	–	NILGA
Mary O'Neill	–	NHSCT
Maura O'Neill	–	WHSCT
Nick Harkness	–	Sport NI
Prof. Barbara Livingstone	–	University of Ulster, Data
Rob Phipps	–	DHSSPS
Sam Knox	–	SGEHC
Sharon Lawlor	–	D.Ed
Siobhan Fitzpatrick	–	Early Years (NIPPA)
Sonia Montgomery	–	WHSCT

Annex B

ADVISORY GROUP MEMBERSHIP

Food & Nutrition

Maria Jennings (Chair)	-	Food Standards Agency
Alan McMullan	-	DE
Andrea Marnoch	-	Food Standards Agency
Andrew Dougal	-	NICHSA
Angela McComb	-	Health Promotion Agency
Cliodhna Foley Nolan (or rep)	-	Safefood
Gerry Bleakney	-	EHSSB
Caroline Kerr	-	Playboard
Judi McGaffin	-	WHSSB
Glynis Henderson	-	CCEA
Martina McNulty	-	Southern Group Environmental Health
Mandy Gilmore	-	Southern Trust
Maura O'Neill	-	Western Trust
Rob Phipps	-	DHSSPS
Ian McClure	-	DHSSPS
Claire Wright (Secretariat)	-	DHSSPS

Physical Activity

Nick Harkness (Chair)	-	SportNI
John News	-	SportNI
Brendan Bonner	-	WHSSB
Gillian McClay	-	Playboard
Jill Fitzgerald	-	DE
Kim Kensett	-	EHSSB
Ciaran Mee	-	DCAL
Neil McGivern	-	SEELB
Andy Bready	-	DRD
Nicola Browne	-	Health Promotion Agency
Jack Palmer	-	DCAL
Sabrina Lynn	-	Southern Trust
Valerie Richmond	-	Limavady Council
Rob Phipps	-	DHSSPS
Ian McClure	-	DHSSPS
Gary Maxwell	-	DHSSPS
Claire Wright (Secretariat)	-	DHSSPS

Data & Research

Prof Barbara Livingstone (Chair)	-	UU
Frank Kee	-	QUB
Ruth Balmer	-	FSA

Gillian Gilmore	-	HPA
Nicola Armstrong	-	Research & Development Office
Hilary Johnston	-	NHSSB
Helen McClure	-	DE
Marita Hennessey	-	Safefood
Kevin Balanda	-	Institute of Public Health for Ireland
Dr Christine McMaster	-	EHSSB
Kieron Moore	-	DHSSPS
Bill Stewart	-	DHSSPS
Rob Phipps	-	DHSSPS
Gary Maxwell	-	DHSSPS
Claire Wright (Secretariat)	-	DHSSPS

Prevention, Education & Public Information

Siobhan Fitzpatrick (Chair)	-	Early Years (formerly NIPPA)
Denise Boulter	-	DHSSPS (Nursing)
Anne Madden	-	NICHSA
Sharon Gilmore	-	FSA
Andrew Castles	-	Safefood
Andy Bready	-	DRD
Jill Fitzgerald	-	DE
Rob Phipps	-	DHSSPS
Ian McClure	-	DHSSPS
Claire Wright (Secretariat)	-	DHSSPS

Annex C

Links to key Documents and Information

Foresight Tackling Obesities: Future Choices
http://www.foresight.gov.uk/

Healthy Weight, Healthy Lives
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082378

Little Steps – go a long way
www.littlesteps.eu/site/contact

Fit Futures
www.dhsspsni.gov.uk/ifh-fitfutures.pdf

Fit Futures Implementation Plan
www.dhsspsni.gov.uk/fit-futures-implementation-plan.pdf

Northern Ireland Audit Office report on Obesity and Type Two diabetes
www.niauditoffice.gov.uk/pubs/onereport.asp?

Investing for Health (IfH), published in March 2002
www.dhsspsni.gov.uk/show_publications?txtid=10415

WHO: "Nutrition, Physical Activity and Prevention of Obesity: Recent Policy Developments in the WHO European Region"
www.euro.who.int/Document/NUT/Instanbul_conf_ebd01.pdf

GP Contracts
www.dhsspsni.gov.uk/index/hss/gp_contracts/gp_contract_directions.htm

National Institute for Health and Clinical Excellence (NICE) clinical guideline
www.nice.org.uk/Guidance/CG43

House of Commons Health Committee Report (2003-04)
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4098721.pdf

National Physical Activity Strategy 'Let's Make Scotland More Active'
www.sctoland.gov.uk/Publications/2003/02/16324/17896

Scotland's White Paper on Nutrition, Overweight and Obesity May 2007
www.scotland.gov.uk/Topics/Government/International-Relations/Europe/EuropeanStrategy/EU-Priorities/PriorityNutrition

Health Eating, Active Living: An action plan to improve diet, increase physical activity and tackle obesity (2008-2011)
www.scotland.gov.uk/Publications/2008/06/20155902/0

Food and Fitness Implementation Plan for Children and Young People
Welsh Assembly
http://wales.gov.uk/topics/health/improvement/food/food-fitness/plan/?lang=en

Annex D

Logic Model

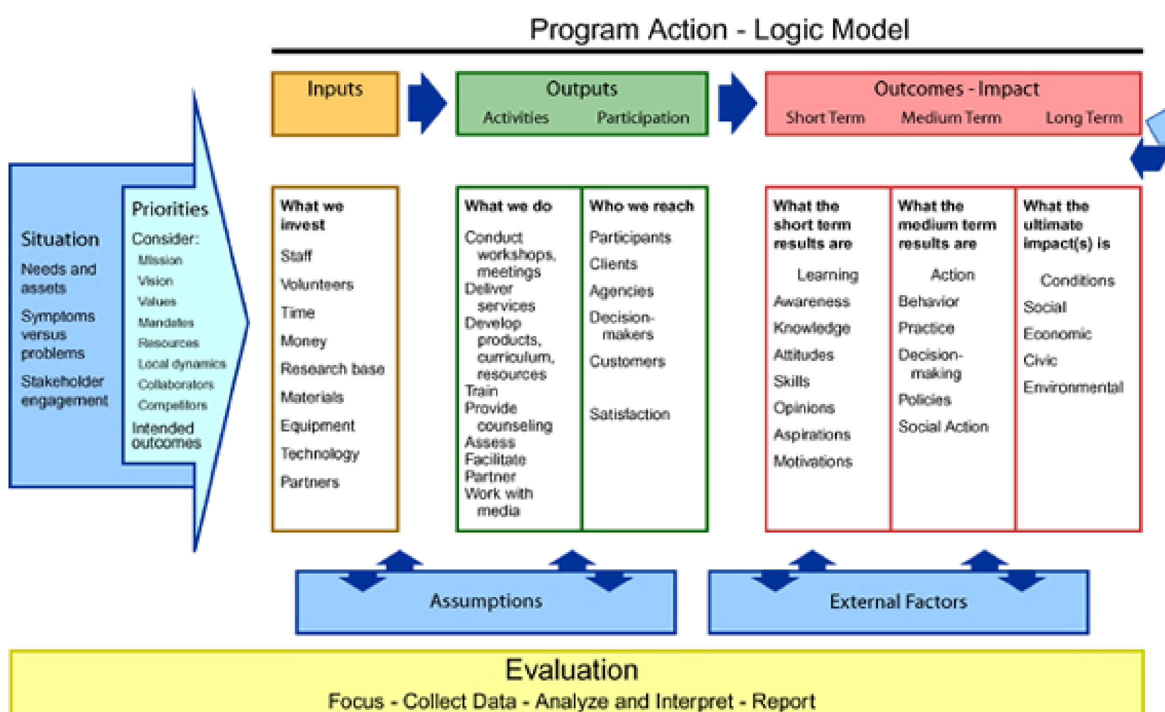
In its simplest form, the logic model analyzes work into four categories or steps: inputs, activities, outputs, and outcomes. These represent the logical flow from:

1. inputs (resources such as money, employees, and equipment) to
2. work activities, programs or processes, to
3. the immediate outputs of the work that are delivered to customers, to
4. outcomes or results that are the long-term consequences of delivering outputs.

The basic logic model typically is displayed in a diagram such as this:

INPUTS --> ACTIVITIES OR PROCESSES --> OUTPUTS --> OUTCOMES

This can also be expressed thus:



Logic models have been developed elsewhere in respect of addressing obesity. They facilitate a focus on outcomes, but also enable an integrated approach (cross-sectoral) to be developed.