Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Departmental Response to the Committee Report on Obesity

4 February 2010

NORTHERN IRELAND ASSEMBLY

_____

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

_____

Departmental Response to the Committee Report on Obesity

_____

4 February 2010

Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Dr Kieran Deeny
Mr Alex Easton
Mr Sam Gardiner
Mrs Dolores Kelly
Mr John McCallister
Mr Conall McDevitt

Witnesses:
Dr Naresh Chada)
Mr John Farrell) Department of Health, Social Services and Public Safety
Mr Rob Phipps)

The Chairperson (Mr Wells):

Good afternoon and welcome. Your faces are not new to us, and some of you have been witnesses recently. I welcome Dr Naresh Chada, who is a senior medical officer; Mr Rob Phipps, who is head of the health development policy branch in the population health directorate; and Mr John Farrell, who is from the primary care directorate. You know the routine here well. You have 10 minutes in which to make your presentation, after which Members will ask questions.

Dr Naresh Chada (Department of Health, Social Services and Public Safety):
Good afternoon. My role, which will be familiar to you, is to advise the population health directorate and the Chief Medical Officer's group on issues relating to public health.

We welcome the Committee's interest in obesity and thank you all for the time that you have committed to producing the report. We are here today to present our response to the report, much of which resonates closely with the Department's thinking. As you worked on the report at such length, you will be aware of many of the statistics and facts about obesity levels in Northern Ireland. Therefore, I will not trouble you by repeating those again, but I remind you that the prevalence of obesity in Northern Ireland is comparable with Europe and North America. Therefore, it is not a local issue. We can learn a great deal through maintaining communication with colleagues from across the water in Westminster, Scotland and Wales. It is also important for us to monitor progress in other countries, such as the United States, Australia, New Zealand and the rest of Europe.

The Department addresses obesity in three different ways: through primary care, secondary care and public health. Members will be aware of a particular focus in primary care on managing obesity in order to prevent the onset of serious chronic conditions, such as heart disease and diabetes. In secondary care, the focus is on the more serious issues related to obesity: for example, providing bariatric surgery to treat obesity. Public health's strong emphasis is on prevention and trying to encourage an improvement in associated lifestyle behaviours, such as diet and physical activity.

The development of the obesity prevention strategic framework provides the current focus for public health and preventative work in the Department. The framework is being developed through the obesity prevention steering group, which was established in 2008 specifically to tackle the rising prevalence of obesity, particularly in children, in Northern Ireland. However, it soon became apparent to us and the steering group that obesity had to be addressed through a population-wide mechanism. Therefore, the framework was expanded to include recommendations for the entire life course of the population.

The obesity prevention strategic framework contains a strong representation from other Departments. In the past, we have spoken about the importance of cross-departmental support, in particular from the Department of Education (DE), the Department of Culture, Arts and Leisure

(DCAL); the Department for Regional Development (DRD); the Department for Social Development (DSD); and the Department of Agriculture and Rural Development (DARD). All those Departments are involved in working on that framework, which is an excellent example of cross-governmental working.

The Department of Health, Social Services and Public Safety (DHSSPS) has also established a small cross-directorate working group to ensure a co-ordinated response to obesity in the Department. It is important for us in the Department to be aware of all the different actions and initiatives that are ongoing.

My colleagues and I will now address the recommendations that are made in the report and briefly outline our response. I will hand over to Rob Phipps from the health development policy branch, in whose work area obesity currently resides. Rob will demonstrate to the Committee how many of the recommendations are already being met.

Mr Rob Phipps (Department of Health, Social Services and Public Safety):
If the Committee is happy, I will go through each of the report's 24 recommendations briefly. I hope that members have the recommendations in front of them, and I will go through them in order.

The first recommendation is about the need to develop a comprehensive and robust strategy. As Dr Chada mentioned, we are developing an obesity prevention strategic framework. I am more than happy to update the Committee on where we are with that. The recommendations of the 'Fit Futures: Focus on Food, Activity and Young People' report are still being implemented, and our new strategic framework will include elements of that report. The recommendations of the report and the work that was done in compiling it will form part of the new life course approach.

The new life course strategy will be developed in partnership with other Departments. The steering group's independent chairperson is Professor Ian Young from Queen's University. Its membership includes officials from DARD, DCAL, DE, the Department for Employment and Learning (DEL), DRD and DSD. We have, therefore, a strong partnership with other Departments.

Recommendation 4 is on funding. As we develop the strategic framework, we will also consider the financial implications, and, in the future, we may be required to submit a bid for additional resources. The current consensus is that the project is probably best led by our Department, but in partnership with other key stakeholders. There are issues about the roles of DHSSPS and other Departments, but, at the moment, it is agreed we will take the lead but will clearly acknowledge the role of other Departments. Similarly, the Public Health Agency, to which the Committee will speak after we give evidence, also has a key role in the implementation of the new strategic framework.

Recommendation 7 concerns the audit of existing obesity-related initiatives and the development of a central database. The Department's data and research group is made up of researchers and statisticians. We have already identified auditing and the centralisation of data as issues and agree with the points made in that recommendation.

Recommendations 8 and 9 relate to primary care. An enhanced service, which is provided by GP practices, enables the early detection and subsequent provision of follow-up services to patients with a body mass index (BMI) of over 30. The General Medical Services (GMS) contract is UK-wide, and the Department continues to influence the development of the quality and outcomes framework (QOF) and clinical indicators. We continue to work with other UK Health Departments and the National Institute for Health and Clinical Excellence (NICE) to make further improvements to those indicators. Until then, the obesity element of the long-term condition management in the Health Service will continue in Northern Ireland.

Recommendation 10 focuses on a comprehensive review of weight management services. The Health and Safety Executive (HSE) board is engaged in a bariatric surgery pilot programme, referral guidance for which has been provided to GPs.

Several recommendations concern strategic work on food. The most positive comment that I can make is that the Food Standards Agency (FSA), which is our partner in advancing our work, continues to develop its traffic light system for food labelling. Recommendation 13 is about food promotion, pricing and portion size. As we developed the strategic framework, portion sizes were identified as a core issue, and the FSA is discussing the matter with major catering businesses.

Recommendation 14 is on the subject of the messages that are sent out about food, which is an issue that is often discussed. The Public Health Agency, through its nutrition publications for the public and professionals, ensures that the five-a-day message and information about what constitutes a portion are conveyed as accurately as possible.

I am not sure whether many people know, but, in late December, the 10-year Northern Ireland strategy for sport and physical recreation, Sport Matters, was approved by the Executive, and DCAL is considering plans for its launch and implementation.

Recommendation 16 reinforces the notion that all Departments should be involved. As I said, the steering group includes a number of Departments, and we are holding bilateral meetings with various Departments to discuss obesity-related issues.

Recommendation 17 calls on the Department of Education to make at least two hours of PE a week in schools compulsory and subject to regular monitoring. In line with DCAL's 10-year strategy for sport and physical recreation, the Minister of Education committed to establishing, by 2010, a baseline for the number of children of compulsory school age who participate in a minimum of two hours of quality physical recreation. She further committed to providing, by 2014, every child here over the age of eight with the opportunity to participate in at least two hours a week of extra-curricular sport and physical recreation.

Recommendation 18 urges the full involvement of local councils in public health. Local councils are represented, for instance, on the physical activity advisory group. Last week, we held a stakeholder event on the physical activity programme and the various outcomes, at which local councils were well represented. We continue to engage and have a good level of contact with them.

Recommendation 19 urges the Minister to work with UK colleagues to ban, over time, broadcast advertising. Broadcast advertising is not a devolved matter, and, therefore, the duty to respond on that matter remains with the UK Government. Nevertheless, the advertising of products that are high in fat, salt and sugar has already been banned on terrestrial TV during children's programming. Through our work, we can recommend further lobbying for tougher regulations. Our role in the matter will be one of advocacy.

Recommendation 20 calls on the Minister to develop a comprehensive media approach. The Department's prevention, education and public information group aims to encourage the delivery of clear, co-ordinated and consistent messages, and we are keen to achieve that goal.

Recommendation 21 calls for the Executive's views on the potential impact of the obesogenic environment on the health and well-being of the population and for the Executive to recognise the fact that that is a cross-sectoral matter. We must ensure, therefore, that all policy decisions are subject to an obesity-proofing exercise. We continue to advocate the use of health impact assessments (HIA). Departments can use an existing HIA tool, and we encourage them to do so.

Recommendation 22 deals with health inequalities and the relationship between high levels of obesity and areas of social deprivation. The values and principles in our framework include equity and inclusion, and a number of draft outcomes refer specifically to health inequalities and targeting areas of social deprivation, so we recognise the importance of that subject.

Moving on to the final two recommendations, our framework recognises the increasing emphasis on promoting healthy lifestyles in the workplace. For instance, Business in the Community is represented on the promoting physical activity advisory group, with which we have a relationship through the HSE.

We urge the Department to examine how data collection can be improved. We have a data and research group, and a key issue for us is to examine the child health system to ensure that we obtain accurate and robust data. There are issues about the ability of data to inform and measure progress. At the moment, we collect data for primary 1 children, and we intend to collect the same level of data for primary 7 children.

Dr Chada:

I thank Rob for providing us with a progress update on the report's recommendations. I will now provide a brief summary. We recognise the importance of tackling obesity across the life course, and the Department is addressing, or has made plans to address, the Committee's recommendations. From what Rob said, members will know that there is a strong cross-departmental and cross-sectoral input into the framework and the steering and advisory groups, particularly from the Department of Education and the Department of Culture, Arts and Leisure.

Fit Futures continues to be implemented, but it is important to recognise that the programme will be built on through the development of the new framework. Therefore, nothing has been lost; we are merely improving and enhancing the work that we have done. We are committed to developing an obesity prevention strategic framework this year, but, in the meantime, the actions and initiatives that address childhood obesity in support of Fit Futures will continue.

Of course, some challenges remain, particularly those that relate to the obesogenic environment and tackling long-term lifestyle issues in a world in which public health professionals are often put under pressure to produce short-term outputs. We hope that the obesity prevention strategic framework will be able to address those challenges.

The Chairperson:

Thank you for burning off the calories and getting through your presentation so fast. I was impressed by the speed with which you rattled through the recommendations.

Mrs O'Neill:

Thank you for your presentation. It was, with respect, a bit waffly. I say that because, although you welcomed all the Committee's recommendations, you have not set out a definitive plan on how to implement them. I am sure that such a plan is included in the framework and that you are waiting until it is published. However, there is no mention of how the recommendations will be implemented, and I will pick out some instances on which you may be able to provide some more information.

You said that you will seek Executive approval on the framework in 2010. It is already 2010, so when will that happen?

Mr Phipps:

I will explain the process behind the development of the framework and its timing. Our approach is based on the idea of developing a life course approach. In addressing obesity, the main issues are food nutrition and physical activity. At the same time, the wider environment must also be addressed. Therefore, we have gathered together a group of experts on food nutrition and tasked it with developing a series of short-, medium- and long-term outcomes for the next 10 years. Those people are experts in their field and have been holding stakeholder events and conducting separate meetings. We also have a group of experts on physical activity that has been similarly

active and has been debating all the key issues. We have to bring the findings of those groups together.

We asked those groups what information they would need to measure progress. The data and research group takes those requests for information, suggests what information should be used and asks whether certain types of information can be collected. That process is ongoing, and a fourth group is collating all the information.

We are almost at the stage of identifying all the various outcomes — short, medium and long term — and we intend those to be agreed by the end of March 2010. We will then have to go through a further exercise and start to prioritise. The idea is that the framework will go out to full public consultation in late spring, and we hope to launch it in the autumn. It is a complicated process that concerns a complex issue. However, our key concern is to ensure that all the experts have an opportunity to comment and test us on what we do. At the same time, we want to ensure that the other Departments are included.

We are conducting bilateral meetings with other Departments, including the Department for Regional Development and the Department of Culture, Arts and Leisure, not only the Department of Education. Last week, we talked to the Department for Employment and Learning on the issue of 16- to 18-years-olds in the workplace.

Mrs O'Neill:

I accept that it is a complicated process because of its cross-departmental nature. However, it is important for the Committee that it is completed sooner rather than later.

I want to pick up on a few of the recommendations. At the time of the inquiry, I noticed that DOE was not on the list of those represented on the steering group.

The Chairperson:

You just stole my question.

Mr Phipps:

DOE is represented.

Mrs O'Neill:

I thought that it should be because of the role of local councils.

Recommendation 7 is on the audit of existing obesity-related initiatives. You said that the steering group identified that as an important action to take forward and that you are already involved in developing that. However, you did not say when that will happen. Will you tell us now?

Mr Phipps:

The need for an audit has been recognised, and that may be a short-term outcome. The structure of the framework will be a series of short-, medium- and long-term outcomes.

Mrs O'Neill:

Surely that is vital to informing the way forward, as you must be aware of the position from which you are starting.

Mr Phipps:

Yes.

Mrs O'Neill:

On the issue of the two hours of compulsory physical education in recommendation 17, I note that you lifted DE's contribution to the DCAL strategy, namely that the Minister of Education has agreed to establish a baseline, by 2014, for the number of children of school age participating in two hours of physical exercise. On the back of our report, has there been any correspondence with DE to identify that as a recommendation from the Committee for Health, Social Services and Public Safety?

Mr Phipps:

Yes. DE provided a response to that recommendation. The response that you have is from DE, because it is clearly an issue for that Department.

Mrs O'Neill:

I still do not think that it goes far enough. Perhaps we should write to the Committee for Education asking it to question the Minister on that matter. We took forward an important

recommendation, and, if children are not encouraged to participate in recreation when they are at school, we will be fighting a losing battle. We must pick up on that recommendation.

People are confused about portion sizes, as referred to in recommendation 14. Again, you welcomed that recommendation, but you did not indicate how you will deal with that confusion, or similar confusion about what constitutes five portions of fruit and vegetables a day.

Mr Phipps:

We recognise that clarification is required. We will ensure that any message that goes out will be clear. However, we must agree on what that message should be, and we expect some discussion on that. Various organisations have an input, and together they will provide the necessary clarification. That is another of the short-term outcomes.

Mrs O'Neill:

I could go through all the recommendations, but I must leave some for other members.

Dr Deeny:

I want to add my voice to what was said about schools. Merely giving children over eight years of age the opportunity to participate in at least two hours' physical activity each week is too flimsy. The current recommendation is for schools to include two hours of physical education a week in the curriculum. Therefore, the new proposal is not even as strong as the current arrangements; it is simply not enough, and I feel strongly about that issue.

I declare an interest in primary care. I wish to focus on recommendation 8 of the Committee's report, namely that the Department should develop a range of evidence-based referral options. I do not have our entire report in front of me, but I am pretty certain that your response is not exactly what we sought. I am disappointed that your approach seems to be one of waiting until problems arise.

You focus on dealing with people whose BMI has gone above 30. I take on board what you have said about the number of days that GPs spend focusing on people who have become obese. However, much of the Committee's focus was on the prevention of disease and the promotion of health. Your response does not have a similar focus. The Department and the Health Service are not being long-sighted enough. We are forever examining problems once they arise and

considering ways of saving money only at that stage. We should be more long-sighted and consider measures that will save us a great deal of money in the long term.

I will go through our report again, but I would like an update from the Department on how we, in primary care, can prevent obesity through exercise rather than diet. For example, primary care health professionals could pick up on kids who are obese but do not yet have type 2 diabetes and make the necessary referrals for leisure activities, and so on. That could help to prevent or, at least, curb the epidemic of type 2 diabetes, thereby saving a great deal of money and creating a much healthier population.

I know of some pilot schemes, and, indeed, a patient asked me about those as recently as yesterday. I saw a leaflet advertising a leisure centre in Omagh, which stated that a patient could be referred if it was deemed appropriate by his or her GP; in other words, if that GP was participating in the scheme. What results have the pilot schemes, in which GPs refer people for leisure activities on the National Health Service, produced so far? Why are only certain GPs and certain health practices participating in those schemes? If we are really serious about achieving a fitter population, those schemes should be rolled out to all practices.

Dr Chada:

I will make some remarks and then ask some of my colleagues to provide more detailed answers. Dr Deeny makes the important link between obesity and type 2 diabetes. Statistics indicate that, if obesity levels continue to grow at current rates, about 85,000 people will have type 2 diabetes in Northern Ireland by 2015. We fully take on board that extremely important issue.

Dr Deeny also referred to the link between public health and the provision of preventative services that can help us to pick up on people before they become obese. We ought to be doing something a bit further upstream, and the strategy that Rob is producing will be at the heart of what we try to do. We want to take an upstream approach to obesity prevention and thereby reduce the levels of chronic disease. I invite John to talk in more detail about some of the primary care issues that have been raised.

(The Deputy Chairperson [Mrs O'Neill] in the Chair)

Mr John Farrell (Department of Health, Social Services and Public Safety):

We accept that the evidence base that is currently in use focuses on patients who are over the age of 16 and that there is not such a strong evidence base for children under 16 years of age. We need to consider that. However, we are mindful that two elements in the primary care general practitioner's setting consider obesity. Our quality and outcomes framework has an indicator that targets people who are aged 16 and over. It aims to identify and maintain a register of patients with a BMI that is greater than 30. That will be used as the basis on which GP practices take forward the direct enhanced service for patients, offer onward referral to leisure centres or encourage them to take up leisure activities such as walking to work rather than taking the car.

We are working with the other Health Departments in the UK to create something in the quality and outcomes framework that is more outcome-focused in how it addresses obesity in primary care. We will consider whether there are opportunities to include young children in that to ensure that it does focus only on those aged over 16. However, we must be mindful that the report referred to other initiatives and picked up on what might happen in schools, the rest of the education sector and in other areas of government.

That is not a real response to the question. However, we are mindful of that and will try to prioritise it in our overall priorities. At this time, one key constraint is the resources. We may need to find additional resources to fund something through primary care to determine how to make that happen. However, we want to make progress on those issues on a four-country basis.

(The Chairperson [Mr Wells] in the Chair)

Dr Deeny raised the issue of pilot schemes. The only comment that I can offer is that those schemes are run as local enhanced services and commissioned by the Health and Social Care Board. Therefore, they are not directed by the Department, and any funding or specification for them has been designed by the Health and Social Care Board and will be rolled out in specific areas of Northern Ireland for that purpose. I am not aware of the outcomes of those schemes, but I will follow that up with the board and respond to the Committee.

Dr Deeny:

I take your point. In the future, will there be provision to allow primary healthcare professionals

to take action to prevent people's BMI from moving over 30, or must we wait until it reaches that level? I used kids as an example. However, we need to play our part in wider disease prevention and health promotion.

Dr Chada:

It is extremely important to empower primary care professionals with the ability to deal with emerging obesity in their practice population. John outlined some initiatives that we are trying to establish or hope to put in place in the future. I take Dr Deeny's point that we need to consider a much broader strategic way on how to train primary healthcare professionals and how to provide them with adequate means and resources. I am sure that the steering group is working on that matter with the subgroups.

Mr Phipps:

We have discussed the Health Service's role in primary prevention, and it includes primary care. Therefore, it is certainly an issue, especially in the physical activity group. The notion of vouchers for leisure centres is not a new one. We are aware of that, I have made a note of it, and we will consider it again.

The Chairperson:

I want to return to the issue of bariatric services. The Committee's report contained a couple of symbolic recommendations. The Deputy Chairperson and Kieran mentioned the idea of two hours of compulsory physical activity. Moreover, we need a dedicated bariatric service in Northern Ireland for people in the Province. The response to recommendation 10 refers to a pilot scheme that closed for referrals on 20 November 2009. You have engaged two contractors in England to carry out clinical assessment and surgery. Where are those two individuals? Are they coming here?

Dr Chada:

You summarised the basis of the current pilot scheme extremely well. We would have to defer to our secondary care group to be able to provide you with more detail about that. We are aware of the numbers of people going through the pilot scheme at present, and it will be evaluated when it ends. However, if you have specific questions about that —

The Chairperson:

Do the folk who are treated by those two clinicians go to England for that treatment, or do the two clinicians come here to help people who require that type of surgery?

Dr Chada:

The Belfast Health and Social Care Trust administers the pilot scheme. I will find out exactly where the treatment is being carried out and get back to you. People who are referred to the pilot scheme must undergo an evaluation process. They are then prioritised for the appropriate treatment. If you indulge us, we will get you the details of how that pilot operates.

The Chairperson:

My understanding is that they have to go to England for the surgery.

Dr Chada:

That is also my understanding, but I need to check the detail.

The Chairperson:

The Department could have indicated a level of seriousness had it sent out a clear signal that the policy on 31 September 2010 is that all children must take part in two hours' compulsory physical activity and that a dedicated bariatric clinic was to be set up in Northern Ireland to deal with people on the waiting list with that condition.

I get the impression that many well-meaning suggestions and policies are emerging from the Committee's recommendations. I do not get the overall view that the Department takes the obesity issue as seriously as the Committee, in that it could overwhelm the National Health Service by 2050 if obesity is not dealt with. I would have liked to see that the low-hanging fruit had been picked, and I thought that those two recommendations were instant hits.

Michelle asked whether DOE is represented on the steering group. I am glad to hear that it is, although that is not mentioned in the documentation. Wearing my planning hat, however, I have not seen the remotest indication that the planners are preparing to encourage us to have a more fit and active lifestyle. Indeed, the recommendations are for more car parking so that we can park as close as possible to our shopping centres or homes. Northern Ireland people do not want to drive to the shops; they want to drive into the shops. Much planning seems to facilitate that.

Dr Chada:

The Chairperson's point highlights the challenges that we face. People's behaviour and cultural changes over the past two decades mean that we live in a much more obesogenic environment, whether through access to high-quality foods or the disincentive for physical activity. The Chairperson is right: we must involve other Departments such as the Department of the Environment, which we have done, and to ensure that architects, planners and those working on transport matters are also involved.

We talked about the cross-departmental issues as part of ensuring what we do about obesity is more joined up. However, we also need to talk about interdepartmental issues. The Department is examining all its obesity initiatives, whether in primary care, secondary care or public health, to ensure that we know what all sections of the Department are doing and have an overview of what we are doing to tackle obesity.

The Committee's report is extremely welcome. It resonates with the Department's thinking, and it is consistent with a great deal of what we are trying to achieve.

Mr Phipps:

In a way, the Department is still developing in that area. I would be somewhat disappointed if the Chairperson did not see the issues that he mentioned, including the low-hanging fruit, as an absolute short-term outcome when the Department launches the framework. That is what the Department is doing.

As far as planning is concerned, it is recognised that, for delivery on those issues, we must ensure buy-in from a range of Departments. The Department's key objective is delivery. You will see the range of short-term outcomes in the framework document, which will be put out for public consultation. Those will include outcomes for the planning environment and the built environment. You described low-hanging fruit. I hope that, when you read the framework document, you will realise that we have taken account of the points in the Committee's report and the issues that people have raised. We debate and discuss all those points, and we are trying to put in place a framework that will deliver on them. Otherwise, we would run the risk of becoming too aspirational. That is part of the challenge that we face. Members may think that, at present, we sound aspirational. However, when they read the document and the outcomes, that

impression will be remedied.

Mr McCallister:

I agree with the Chairperson's point. I am glad that the Committee's report has been welcomed as a contribution to planning issues. Over the past 20 to 25 years, the change in physical activity levels is a huge concern. All members support Michelle's point.

What is the timetable? Have you a target date for the framework going out to public consultation?

Mr Phipps:

We aim to do that in late spring, or perhaps in June, and we are on target. We are involved in a pre-consultation exercise, and the last thing that we want to do is miss anyone out at this stage. After the consultation, we will pull the whole thing together, and that will involve bilateral talks with other Departments to ensure that there are no surprises for them.

Mr McCallister:

What about health inequalities? The need to address higher levels of obesity in areas of social deprivation is a key target. Later today, we will talk to representatives of the Public Health Agency about addressing health inequalities. Will you develop that key point? Will you put some meat on the bones and set early challenges?

Mr Phipps:

Health inequalities are an issue, and a range of lifestyle behaviours involves a relationship between deprivation and threats to health, tobacco being a classic one. There are also other threats.

Mr McCallister:

Are both tobacco and alcohol such threats?

Mr Phipps:

Yes, they are. We examined all those Investing for Health strategies. That is a given; we have completed all that targeted work. The framework document will set a challenge to organisations and agencies, such as the Public Health Agency, to ensure that their work addresses that. A

challenge exists there. I do not want to speak on behalf of the agency, but its representatives regard one of its key roles as addressing health inequalities on a range of issues; the Minister was clear about that. In England next week, a report will be published about the social determinants of health. The relationship between those social determinants of health guides us in what we do.

Mr Easton:

I am pleased by what has been brought before us today. Many of our ideas square with yours, and I find that encouraging. The document is at an early stage, and we should judge your actions when we receive the framework document. That will help to put meat on the bones and show us whether you are proceeding as we want you to. Although there was some criticism, the points are well made, so do not be disheartened.

I am particularly interested in recommendation 22 on targeting areas of deprivation. I hope to get the Kilcooley estate in Bangor involved in that, because it is an area of neighbourhood renewal. I am interested to know how you will identify areas of deprivation, what Departments you work with to do so and what you intend to do in those areas. I know that that is still in its early stages, but perhaps you can fill me in.

Mr Phipps:

The DHSSPS works closely with DSD on neighbourhood renewal. At a geographical level, that is the Government's approach. At the same time, it is open to local areas to engage with local deliverers. The framework enables local action. At a strategic level, we work with other Departments, and, within our framework, we will prioritise some of that work. One difficulty is that we could have thousands of outcomes, which, clearly, would be too many.

We are realistic about the current resource situation and, dare I say it, the possible future resource allocation. In those circumstances, it may be that, within the framework, there will be certain priorities around ensuring that attention is given to areas of deprivation and also to groups. Deprivation can be addressed geographically, but vulnerable groups are also affected.

Mr Easton:

How do you envisage paying for that? The DHSSPS will have to pay for some of that, but will the cost be spread proportionately to the size of other departmental budgets? Will the DHSSPS pay the bulk of the money, or will other Departments contribute what they deem appropriate to

their input?

Mr Phipps:

I envisage some interesting discussions. The DHSSPS has a budget. However, bilateral talks are vital, and we will discuss, with other Departments, their work as part of their business plans and the type of funding that they can provide. At the moment, there is not one big pot of money, and it is a matter of individual Departments working together. That is why we work with other Departments to ensure that their work is appropriate. Discussions with other Departments centre on ownership of various outcomes and the priorities allocated to each Department.

Mr Easton:

I have one final question. How do you envisage yourselves monitoring the outcomes, 10 or 20 years down the road, and how are you planning for that?

Mr Phipps:

As I said, we have a data and research group, we are putting in place several key indicators, and there are targets for decreasing the level of obesity. However, participation in physical activity and increasing the level of knowledge are also important. The need for a consistent message was mentioned, and perhaps we should measure people's attitudes and understanding. A group is developing those issues, and we are trying to identify 10 key indicators. The intention is that, from next year, there will be an annual health survey, which will also provide us with information.

The Chairperson:

There are 11 minutes remaining for questions. Therefore, I will split that time evenly between Conall's and Sam's questions.

Mr McDevitt:

I want to pay tribute briefly to those who formulated the report. I see a great deal of commitment from the Department, and I do not want, in any way, to take away from today's positive comments.

Mr Phipps, have you made any specific budget allocation for tackling obesity this year?

Mr Phipps:

We have a budget allocation, which is already being spent on progressing Fit Futures, physical activity and food nutrition. Therefore, the Health and Social Care Board and the Public Health Agency already have money for those purposes.

Mr McDevitt:

Have you made any budget allocation for the strategic framework?

Mr Phipps:

At present, we use the existing budget.

Mr McDevitt:

Will the budgeting resource be available in September, when the framework document is published, to enable you to kick-start the process with some speed and some low-hanging fruit?

Mr Phipps:

We certainly have the existing budget.

Mr McDevitt:

What amount of time has been dedicated to the development of the framework in the Department? Can the three witnesses give me an indication of the proportion of your working week that is dedicated to that?

Mr Phipps:

That is a good question. I have my calendar here, if you would like to see it.

Mr McDevitt:

I am not trying to catch you out, but is it your number one priority?

Mr Phipps:

I am happy to tell you. My branch has responsibility for the alcohol and drugs strategy and for Investing for Health. Therefore, my time is split across those areas. However, others are dedicated to the development of the framework.

Dr Chada:

We must recognise that it is not only Rob who devotes his time to the issue. He has a team of people who work across an extensive range of public health issues. As for my time, the development of the framework is an extremely important piece of work, but I advise the Department on a range of medical and public health issues, of which that is only one. I spend much of my time on public health, and that ties in with many other lifestyle issues in which I am involved, particularly smoking cessation. Other divisions in the Department are also involved, but it is difficult to quantify. However, tackling obesity is a high priority.

Mr Phipps:

We work on that area daily. It is part of our bread-and-butter work.

Mr Farrell:

Primary care is intrinsic to everything else that we do. We cannot say that we work on it for a set period of time each week, but a team of people works on it.

Mr McDevitt:

Under recommendation 10, you raised the issue of people potentially being sent to England for bariatric surgery or treatment. Will you give us a breakdown of the costs? How much did it cost to run the regional pilot scheme here, and how much does it cost to make the current arrangement?

Dr Chada:

We would be delighted to provide you with more detailed answers on the pilot scheme. I apologise for having focused more on public health matters. We obviously have some information about the pilot scheme, but I do not wish to do anything other than give the Committee the most accurate information, and that might be best done through correspondence.

The Chairperson:

The Committee's view is that there is a strong case for that unit to be based entirely in Northern Ireland. The unit should be staffed by local people and serve the community. The issue of obesity is on the increase, and that would have clearly indicated how seriously you took the issue. We would be grateful for that information.

Mr Gardiner:

On recommendation 14, what is your interpretation of a portion of fruit? You recommend that five portions be taken a day, but what would you say is a portion? Is it a whole orange, a whole apple, a whole banana or a whole pineapple? You do not make it clear.

Dr Chada:

The five-a-day issue has been with us for some time, and the Department and the Food Standards Agency have tried to convey a clear message. There is much confusion about what constitutes a portion of fruit or vegetables. One portion of fruit might be, for example, an apple.

Mr Phipps:

We will send you all the relevant current information.

Mr Gardiner:

Why can you not tell the Committee? I am sure that my colleagues would like to know your interpretation of a portion. Do I have to eat an apple, an orange, a banana, a pineapple and a melon every day, or a portion of an apple, a portion of a banana and a portion of an orange, and so forth?

Mr Easton:

Or a smoothie?

Dr Chada:

An individual piece of fruit generally constitutes a portion, as do many portions of vegetables. There are other examples of the ingestion of fruit and vegetables, such as, for example, a glass of orange juice. However, that could not be used as more than one portion of a person's contribution. In some ways, the Committee is right: there is a little bit of confusion in that regard. I hope that I have given some clear examples of what constitutes a portion. It is important that we convey the message so that people fully understand how many of their five portions a day that they ought to eat and, indeed, how to get them.

I have given some examples of a healthy, nutritious approach to eating, which includes eating an apple, a small portion of strawberries or perhaps a portion of vegetables. As long as people do not have misconceptions about what constitutes one of their five portions a day, we will be able to

get those messages across in a more effective way.

The Chairperson:

One way to guarantee that people eat their five portions a day is for them to become vegetarians, like me. If vegetarians do not eat five portions a day, they starve to death. I eat about 15 portions a day.

Dr Chada:

I commend the Chairperson for that healthy lifestyle choice.

Mr McCallister:

I do not. *[Laughter.]*

The Chairperson:

A neighbour of mine once described his neighbour as a complete nutcase. He said that he knew that she was mad because she was a vegetarian, not knowing that I was. Some people have strange views about vegetarians.

Thank you very much. As far as I know, those are all the questions that we need to ask. We will watch with great interest when the framework document is published. We would like a great deal of the spirit of the Committee's report to be in the framework. We would be much happier if we saw that.

Mr Phipps:

I have made some detailed notes.