Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Public Health Agency

4 February 2010

NORTHERN IRELAND ASSEMBLY

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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 Carolyn Harper)
Ms Mary Hinds) Public Health Agency
Mr Edmond McClean)
Dr Eddie Rooney)

The Chairperson (Mr Wells):

Ladies and gentlemen, welcome to the Committee. You have had a brief insight about how we operate. I welcome Dr Eddie Rooney, who is the chief executive of the Public Health Agency; Dr Carolyn Harper, who is the director of public health and the medical director; Mr Edmond McClean, who is director of operations; and Ms Mary Hinds, who is the director of nursing. I went to Queen's University with an Ed McClean; is that the same Ed McClean?

Mr Edmond McClean (Public Health Agency):

It is the same one.

The Chairperson:

Good grief. *[Laughter.]* Talk about your past coming back to haunt you. I do not want you to repeat anything that we got up to, Ed, during our time at Queen's.

Mr McClean:

It was a wonderful time.

The Chairperson:

I am completely flummoxed. *[Laughter.]* We like witnesses to give us a presentation of about 10 minutes' duration, after which we ask the members to put down their names for questions. Thank you very much, Dr Rooney.

Dr Eddie Rooney (Public Health Agency):

I hope that you do not hold grudges against people whom you know from the past. Thank you very much for the invitation to appear before the Committee. We have provided a briefing paper. I do not intend to go through it, but, if members are happy, I will highlight a few of the key points. I will then be happy to take as many questions as members wish to ask.

I am conscious that swine flu was in full swing when we last appeared before the Committee. The Public Health Agency had just got off the ground, and we were filling our senior posts. We have made some progress since then: the first three tiers of the organisation — down to assistant directors — are in place. We are in the process of preparing for the fourth and fifth tiers. We still have some way to go, but at least we have made progress in getting the organisation together.

Although much of the agency's initial energy has been on health protection, particularly in response to swine flu, we have put much effort into addressing the full range of factors that lead to premature ill health and death. It is worth reflecting that priorities for action, which guide our priorities, have set the bar very high.

If we are to address regional and local health inequalities, we must close the gap in life expectancy, halt the rise in obesity and contribute to a reduction in suicides, alcohol and drug misuse, smoking, and births to mothers under the age of 17. We realise that that is a considerable task, and although we have made progress across those areas, we are under no illusion whatsoever that there is a long way to go.

There are worrying trends in many of those areas, not least in relation to smoking, particularly among 20- to 24-year olds. Rates of teenage pregnancies are going down overall but are rising quite sharply in some localities, particularly in the west. We are at the start of a long road in our task to reduce inequalities. There are persisting inequalities, and although health is improving in many areas, the gap between rich and poor in many of those areas is growing. Depending on where people live, there can be seven years' difference in their life expectancy. We know that, in more affluent areas, there are pockets of severe deprivation, and all the negative health figures are reflected in those populations.

That leaves us with an enormous task of dealing with issues that affect the fundamental nature of our society and of tackling poverty. We know that changes cannot happen overnight; nevertheless, we are aware that we must take urgent action for long-term benefits. We know that we must take more incisive action. We must tackle the root causes and determinants of ill health. The very nature of those causes means that neither the Public Health Agency nor the Health Service can work alone, because they cut across many areas of government responsibility and local communities.

Our focus is on raising our game when we address the issues. What should we do to make the greatest difference? I will highlight some issues to give members an indication of our direction. It is important to invest in early years intervention. Whether the issue is education, social determinants or health, it is important to invest in taking action at an early age. In our case, that means acting at the prenatal stage through to entry into formal education and beyond. There are many highly regarded international initiatives, the evidence bases of which show the increasing effectiveness of early intervention across a range of social indicators, particularly in health. We are considering those areas carefully for opportunities to apply them here.

We have some strong local examples in which we can see dividends. A few weeks ago, I attended the launch of a parents' support initiative at St Joseph's Primary School in Slate Street in the lower Falls. I listened to evidence from educationalists, the community and parents who backed the engagement and impact of that initiative on many factors affecting young people's lives. That interests us.

We are also conscious that, by examining new initiatives in new areas, we cannot overlook the major health risks that are staring us in the face. Our ability to tackle smoking reduction more effectively than we have done will deliver enormous benefits.

This week, my colleague Carolyn has been working with people from a number of agencies to assess the evidence on effective interventions on smoking and to help us to decide where we should direct our efforts to bring down the rate of smoking. When the outcome of that work has been written up, I will be happy to share it with the Committee.

Along with our colleagues on the Health and Social Care Board, we are engaged in a major drive on mental health. We are also involved in a range of programmes on issues such as tackling obesity, which was discussed earlier, promoting physical activity, tackling alcohol and drug misuse and raising quality and safety standards across the health services.

Since the inception of the agency nine months ago, we have learned about the importance of collaboration. We have a major drive in that area and work closely with local government. We will see the benefits of that over the coming weeks as we consolidate our collaborative work and joint working arrangements with a range of local councils, and clusters of local councils, on a shared agenda about improving health and well-being. The linking of the local dimension is a crucial part of our role, because we need to ensure that that drives the regional emphases.

We recognise the fact that we are tackling complex issues and that we are in territory that often requires a long-term perspective. There is a real sense of urgency in our organisation to ensure that effective interventions are in place as soon as possible, that we learn lessons and that we implement effective new initiatives and new approaches to turn around the figures. The bottom line is that there must be health outcomes.

Through our work, we will ensure that there is a greater emphasis on prevention, because that is what the agency was set up to do. That does not mean prevention only under the label of "public health"; it also means ensuring that prevention is the approach that is used across a range of health and well-being services. We will work closely with our colleagues in the health sector, the public sector and, crucially, local communities to tackle difficult problems that have a profound impact on the lives, and deaths, of people in our community.

The Chairperson:
Thank you for your presentation. Your presence here is very welcome.

The agency has a £59 million budget and seems to have a plethora of targets and programmes on a wide range of public health issues. The Minister says that many of the medical problems experienced by large proportion of those who present themselves as

requiring care or treatment are self-inflicted because they are a caused by lifestyle choices. Is the agency trying to spread itself too thinly? There are some big issues such as obesity, which we have just discussed, and smoking. If the smoking rate in Northern Ireland could be reduced to the Californian target of 10%, that would have an enormous impact on public health. Is it not better to target one or two areas in which policies will produce rapid and significant results instead of the agency's trying to spread itself across a range of worthy causes in which it may be difficult to attain the same level of success?

Dr Rooney:

That is the thinking that has driven local interventions. We deal with some large issues such as teenage pregnancy and smoking. To try to solve all the issues in Northern Ireland will spread the agency very thinly. Will that have an impact? It is part of the equation, but it is not a substitute for focusing on a locality in which we know the issues and where we dealing with it.

We have information that is good enough to allow that level of targeting. Our collaboration with district councils in particular is very much on that local focus. We take bite-sized chunks, choose the issues and areas that we know best and in which we can intervene and ensure that we evaluate and learn from that intervention. It is about rapid turnaround and more incisiveness. Although we must remain focused on regional issues, they are contributory factors. They support local action, which must be further confined and targeted; that is what we intend to do.

Ms Mary Hinds (Public Health Agency):

I realise that the Committee is considering the budget and a long list of priorities, and the two seem not to balance. The agency not only uses its own resources but advises and supports the commissioning process that "purchases" — for want of a better word — the services on the ground.

We work with departmental and board colleagues to develop a commissioning framework that relies more on service frameworks. Those consider prevention through to care in every care environment. Therefore, we try to shift the resources for more traditional services into prevention, alongside our own resources in the Public Health Agency. It is a creative partnership between the agency and the board to try to shift some of the resources that go into secondary care services into primary prevention services and, indeed, into primary care in other areas in which early interventions can prevent, for example, heart disease and acute intervention. Our impact goes beyond just our own budget.

The Chairperson:

You mentioned your link with the Health and Social Care Board. The agency is devising a commissioning plan for 2010-11, which is due in May 2010. Is that plan on target, and will the Committee see that document?

Dr Rooney:

It is on target and will be the joint plan of the priorities that will cover the full health budget. The Committee will see that document through the Department.

Dr Carolyn Harper (Public Health Agency):

I want to add to the comment about leveraging in money from elsewhere. The agency is also leveraging substantial sums from sources such as the Big Lottery Fund for programmes such as neighbourhood regeneration and improving the uptake of benefits, services and grants for people living in poverty. We also received funding from other Departments to administer out to assist them in meeting their targets.

There is a range of sources. However, an economic case can be made for additional funding for prevention and early detection. There is a greater financial impact when, for example, cancers are diagnosed earlier, illness is prevented or poor lifestyle factors are reduced. There are three key high-impact priorities: smoking, obesity and early years programmes. Early years programmes deliver benefits across a range of other outcomes, such as teenage pregnancy, mental health, better educational attainment and bringing people out of poverty. Smoking and the early years programme will be central to reducing the health inequalities gap.

The Chairperson:

The Public Health Agency is up and running and fully fledged. Presumably, the £59 million budget comes from the Department as a block grant. Is the agency subject to the same comprehensive spending review (CSR) efficiency savings as other agencies?

Dr Rooney:

Yes, it is.

The Chairperson:

Therefore, you have to deliver 3% efficiency savings?

Dr Rooney:

Yes, we do.

The Chairperson:

Are you spending any trust money, or is your budget completely separate from the five trusts?

Dr Rooney:

The budgets are separate. Our £59 million budget is accounted for separately through me as the chief executive.

Mr McClean:

I would add that a proportion of our money goes through trusts to provide services on the ground, particularly in health improvement. Our budget is separate, but it is applied, in part, through trusts to enable them to deliver services.

Mrs O'Neill:

I note that sexual health is not one of the agency's priorities. Last year, the Department published a sexual health strategy, but healthcare workers in that field say that some targets have not been met and have not been considered. Does the agency have a role in that area?

Dr Harper:

Sexual health will be further highlighted next year. There has been an increase in cases of HIV, chlamydia and other sexually transmitted infections. There is also a specific target on teenage pregnancy, which is a separate issue. However, a sexual health promotion network is being set up that involves the key organisations, including community, voluntary and trust provider services. That stakeholder group will be led by the agency and will give advice on what we do with the board to commission services. To deal with the issue of sexually transmitted infections, we need a combination of life skills, early intervention and youth programme work, as well as early detection, public and professional awareness of the symptoms and access to acceptable genito-urinary medical services. That involves various issues, and we will work closely with community organisations about outreach services to high-risk groups. Some traditional services are not acceptable or accessible to them.

Mrs O'Neill:

I welcome that. A stigma is attached to this issue, and people are afraid to talk about it. We need to be upfront to tackle the issue. I am concerned because some workers in the field of sexual health say that many targets are not being progressed. I welcome the fact that the

agency will prioritise it.

Dr Harper:

We want to give the issue a momentum and make progress.

Mrs O'Neill:

Is the agency involved with the councils' transition committees? That is a vital role for community planning and tackling health inequalities.

Dr Rooney:

Absolutely. Local commissioning councils are responsible for local community planning, education and early years planning. In many ways, that gives us an opportunity to join up those agendas through practical action. We work closely with the transition committees.

Last night, I was involved in discussions with Antrim Borough Council and Newtownabbey Borough Council on that issue. Our work must be at a pace with the councils, and not everyone is in the same place at present. We are adapting to find an approach that helps each council best. We are not trying to make one size fits all. We will work fully with the structures of the councils to ensure that it all comes together.

The Chairperson:

Before it goes out of my mind, I must ask about the target for bowel cancer screening. Originally, it was a priority for action, and then, as a result of the CSR efficiency savings, it was not, and subsequently it reappeared as a priority. I understand that it is under threat yet again because of budgetary cuts. Where does the target for bowel cancer screening stand at present?

Dr Harper:

We are on track to start bowel cancer screening in April 2010, when it will roll out to various units across the Province. Preparatory work is being done on testing kits, laboratory services and accreditation of the units in which the screening will be done to ensure that they are up to standard. That is all in train.

The Chairperson:

Presumably, early detection of bowel cancer will yield positive outcomes?

Dr Harper:

Early detection is undoubtedly the main thrust of the programme. Survival rates are much higher if bowel cancer is detected early, and treatments are more straightforward. From the public health point of view, it makes economic as well as health sense.

Dr Deeny:

You are all very welcome, and thank you for your presentation. I agree with the Chairperson that you have taken on a lot, but the Committee will help you as much as it can. It is a huge task. I wish to focus on mental health and improving the quality of, and access to, mental-health services.

Eddie, you talked about the emphasis on prevention, and, Mary, you talked about early intervention. For many years, primary healthcare professionals have felt that certain necessary services — talking therapies, counselling and cognitive behavioural therapy — were inaccessible in primary care. The shift from secondary care to primary care is under way, which is to be welcomed, but only if the resources are available in primary care.

What is happening? I know that the issue of waiting times affects all mental-health services, but particularly talking therapies and counselling. Where does the Public Health Agency, which is involved in health promotion and early intervention, stand on that issue? Those of us who work in mental health — up to one third of GP consultations are about mental-health issues — know that, if we can get early intervention and talking therapies in place, that will prevent crises in future. Where do you see early intervention and access to vital therapies sitting in five or 10 years' time, as we try to prevent mental-health problems worsening, as they have been doing for years?

Dr Harper:

I will kick off, and my colleagues may join in. From a primary care point of view, prevention requires the public and patients to be aware of the symptoms and to seek assistance. We must ensure that a range of people, be they a health and social care professional, a clergyman or someone at school or in the workplace, are aware of the symptoms and can pick up on whether someone has potential mental-health problems so that they can signpost various services and programmes for that person. Sometimes, that does not require formal referral to a statutory health and social care service.

Community groups provide counselling programmes, and counsellors can often make a difference through early intervention. Ultimately, it comes down to balancing the demand for

services that have the capacity in the community, voluntary or statutory side with the elective waiting time target. Additional funding has been invested, and additional counsellors are being appointed to provide more talking therapies.

Members have seen the figures for the funding that is available for the implementation of Bamford's recommendations, and we are fully involved in the structures that will take that forward. However, undoubtedly, there is a significant funding shortfall. It is not only about creating a better model of care and better services for patients but about taking resources out of the bricks and mortar of institutional care and putting those into services at community level, including talking therapies. It is about facilitating that shift. We are fully engaged in discussions with the Health and Social Care Board on the issue of service configuration and profile.

Dr Deeny:

I will word my question another way, and then I will shut up. How long do you think that it will be before GPs will be able to refer a patient for talking therapies instead of having to prescribe antidepressants? I am sure that many of us have felt that we have had to prescribe antidepressants to a patient because we felt that the option of talking therapies, cognitive behavioural therapy or counselling was just too far away. When will we reach that stage when those therapies become part of healthcare provision? Primary care deals with more than 90% of mental-health problems, but we do not have all the services that we need.

Dr Harper:

I hope that you will be able to see a difference in a year from now and a substantive impact over the next two, three to five years. Evidence shows that those therapies are as effective, and sometimes more effective, as antidepressants for patients with mild to moderate anxiety or depression whom GPs see routinely. It is about building up that capacity over the next 12 months and beyond.

Ms Hinds:

I wish to reassure you, Kieran, that there is not a more active group of directors in mental health working with their colleagues in the Health and Social Care Board and the Public Health Agency to modernise all mental-health services. That gives us great hope for the future that you will get the very changes that you need.

Dr Rooney:

There are ongoing complementary developments that will help to get effective models in

practice. There are the approaches, for example, around Lifeline and work through trained personnel in the community and voluntary sector in communities to enable rapid identification and follow-up. Those models are being developed. We can apply many of the lessons that we have learned, particularly where the task force on mental health is concerned. However, there is a real sense of urgency from all those who are involved in that area. It is just too important.

Mr McDevitt:

I congratulate the Public Health Agency on its establishment because it is an extremely important, probably the most important, agency that has been established here in recent times in public health terms. I will pick up on the obesity conversation and follow on from our earlier evidence session. What role do you envisage for the agency in the forthcoming strategic framework?

Dr Rooney:

We will have a crucial role at two levels. First is our input and expertise in shaping actions, and we will work closely with the Department. Secondly, we have practical programmes for tackling issues on the ground.

The Public Health Agency is equipped to play an overarching role in the framework. Dealing with obesity is about high-level policy being joined to implementation. A vital role for the agency will be to develop links to bring together all the partners, because the issue must be dealt with at community level. We will have a professional role to input into, and advise on, policy, and we will also have an implementation role.

Mr McDevitt:

On the theme of joining up, it was mentioned earlier that the report back from local government is patchy at best.

Dr Rooney:

Yes, it is.

Mr McDevitt:

I am being generous in describing it as patchy. However, the framework is due for public consultation before June, and the aim is to hit the ground running in September. Will that happen? In your honest assessment, do you think that local government will be capable of assuming the required responsibilities to enable a transformational attitude to public health

across the region?

Dr Rooney:

We have picked up from all councils, individually and in collaboration, that, despite all the uncertainties about reorganisation, there is a realisation that there is an immediate health and well-being agenda. Anything that the agency can do to facilitate the councils to engage and work on that is much appreciated. It is a case of not sitting back and waiting for any part of the system to come together; we must drive actively to make that happen. The foundations that we are laying for our relationship with the district councils and local government will be a springboard that will allow early joint action to deal with the common agenda. The work that we have undertaken will help to move the issue forward.

I will speak wearing a different hat on. I chaired the Fit Futures task force on childhood obesity. One of the things that I found most useful from that was having somewhere to go. I wish that there had been a Public Health Agency at that time to do the joining up after we had finished the discussions. We have come a long way in the system in at least enabling that to happen. It needs drive, and the agency must be a part of that.

Mr McClean:

I reassure the Committee that, when working with local government, we have had nothing but wholehearted support and interest. The issues on the ground are different. Local government takes the issue seriously, considers it thoroughly and fully understands issues of need in their communities and the interventions that have, and have not, worked well.

A good foundation has been built, and work is ongoing. From day to day, the work changes, and it may seem as if some council areas are further behind than others. However, I reassure you that progress across all areas is rapid. We are working with each council cluster to support and stimulate that work further.

Mr Gardiner:

Thank you for your presentation and the documents. Action 1.11 of your briefing paper refers to reducing the incidence of teenage pregnancies. That topic is not often discussed. However, two constituents visited my office last week to outline their problems. The mothers have given birth and are finding it difficult to pay their rent, and they are being threatened with eviction. What advice do you offer on that issue?

Dr Harper:

That outcome would benefit from the early years work that Eddie spoke about. Some issues are trans-generational; a 16-year-old mother could, 16 years later, have a daughter and a granddaughter. Outcomes from some early years programmes and support through childhood are positive ways to reduce teenage pregnancy rates. However, waiting for those to take effect is not the solution. Another key element is the here and now, particularly with programmes on relationships and sexual education in the right environment. For some children, the right environment is school, and there are programmes that work closely with schools on relationships and life skills. The programmes deal with those issues as part of a holistic health education message so that teenage pregnancy is not taken out of context as a single issue.

Other programmes target those children who do not receive the message in school, do not hear it or are simply not ready to accept it at that point. Again, a holistic message is expressed so that it is as much about life skills, life choices and raising aspirations as about pregnancy. There are practical issues about timely access to contraceptive services and the need to have a range of services. Some young people find certain types of service more acceptable than others. We try to cover all those bases. However, the real long-term impact will be made through early years programmes.

Mr Gardiner:

I welcome your points, but you are not as enthusiastic as I would like you to be. There was a campaign based on the fact that smoking causes cancer; you have to try to hit that bar because young girls' lives are being ruined, and families are being wrecked. Young girls may wish to go for a good night out or to have a drink, but they end up having to look after a child. You have to lift the bar of your advertising to forewarn people that teenage pregnancies result in wrecked lives.

Dr Harper:

I am sorry if I gave the impression that we are not fully behind that issue.

Mr Gardiner:

You were not as enthusiastic as I would have liked you to have been.

Dr Harper:

We are 100% committed because we recognise the impact pregnancies have on young people and the difficulty in which it places the child. There is no question about it; it is a priority for

the sexual health promotion network and the STS *[Inaudible.]*

Mr Gardiner:

The problems begin when a child goes to primary school and is told that he or she has no mum or no dad. That affects the child; it is hurtful, and we have to protect that child.

The Chairperson:

Are you aware of the programme delivered by Love for Life in the Southern Trust area? It seems to be effective? It teaches such old-fashioned concepts as abstinence and delay. That programme is available in one area of my constituency; however, it is regrettable that, for a large part of Northern Ireland, it is not available. Have you come across that programme?

Dr Harper:

We have, and we have had discussions with Love for Life. Dr Cullen, who will chair the sexual health promotion network, has also met the organisation. There are several providers in that field, and we will examine the evidence base to see what works best. There should be a range of providers, and, if Love for Life is appropriate, we will think about commissioning it.

The Chairperson:

That completes the questions. Thank you for appearing before the Committee.

I want to move on to swine flu. We have the latest statistics, and, as the Public Health Agency plays a lead role in the swine flu pandemic, having you here is too good an opportunity to miss.

The figures for last week's update are extremely encouraging. No deaths have been recorded and, in week four, the number of new hospitalised cases is zero, and there has been a 17% fall in out-of-hours calls. Those are significant drops in what has been, since November 2009, a long-term trend of major decline. Are we out of the woods? Can we say that the graph clearly shows that the pandemic is over?

Dr Harper:

All the signs indicate that. However, I am always hesitant to say that we are out of the woods; everyone should keep their fingers crossed, because one never knows.

Dr Deeny:

Is swine flu likely to reoccur next winter?

Dr Harper:

It could be that that virus reoccurs or that a new virus emerges. However, pandemics tend to have longer cycles than that. That being said, the surveillance systems for new influenza viruses are now much better than they used to be. Therefore, it may be that, because of stronger surveillance systems, we are more likely to find new viruses emerging as an increasing number of patients become ill. Swine flu was a new virus, and, therefore, a significant percentage of the population did not have immunity to it. That is why it was able to spread and become a pandemic. All the current data indicates that it is time to move on — I am hesitant to say "it is over" — and pick up on other issues.

The Chairperson:

Those of us born in 1957 or earlier are safe from that virus. *[Laughter.]* We lived through previous pandemics and, therefore, can take anything on the chin.

On a more serious level, am I correct in thinking that, in your agency and in the Department, money that had been allocated for a more virulent outbreak has been saved? Perhaps that money can be brought back in and spent elsewhere.

Dr Harper:

I am not aware of that.

Mr Gardiner:

You are beginning to speak like a politician. *[Laughter.]*

Dr Harper:

I am genuinely not aware of that. I know that all funding and all business cases that were put towards supporting expenditure on swine flu were rigorously challenged. It was a robust process under which it had to be demonstrated that expenditure was absolutely necessary. However, it puts us in a good position for any future pandemic, in that systems and equipment have been procured and are in place.

The Chairperson:

When the dust settles, the Committee will examine what happened to the large sum of money that was set aside for a more serious outbreak and whether that windfall can be used to

address other pressures in the Department's budget. The outcome is not what we expected. Obviously, we are delighted that, as a result of prompt action, it seems that we are on top of swine flu. However, the budget was based on a more pervasive virus, but only 260,000 vaccinations have been carried out. We had budgeted for more. Where has that money gone?

Dr Rooney:

It would be better to ask the Department that question. As Carolyn said, our budget concerned business cases for acquisitions that were needed to respond to swine flu. We do not have central control of the budget.

Mr McDevitt:

I have a quick question about the statistics. I am new to the Committee, so I apologise for my ignorance. Figure 3 shows the incidence of swine flu recorded by GPs. The colours are a bit difficult to make out, but the graph seems to show that the highest incidence is among five- to 14-year-olds. However, figure 5 shows that the vast majority of telephone calls about swine flu to out-of-hours GPs are from OAPs; that seems strange. What does that tell us?

Dr Harper:

Dr Deeny may be able to shed some light on that. Five- to 14-year-olds tend to be somewhat more resilient in their symptomatology, whereas older people have higher levels of co-morbidities, which may exacerbate some of their conditions.

Mr McDevitt:

The statistics show that five- to 14-year-olds are going to GP surgeries, yet they also show that OAPs are more likely to call out-of-hours GPs for advice and help.

Ms Hinds:

That may be partly down to the fact that older people, because of their resilient nature, do not want to disturb GPs. By their nature, people in Northern Ireland try to manage alone, but young people will be taken to their GPs by their parents. We know from the swine flu helpline that older people sometimes feel more vulnerable when they are on their own in the evenings. That may have an impact on the statistics. However, that is an entirely subjective commentary.

Dr Deeny:

I assume that advice will be sent to GP practices on how to deal with people who request vaccinations throughout the rest of the winter and the spring. It has been said that swine flu

could occur next winter and the following winter. People who have heard that may want to get their vaccine now to protect them for the next two winters.

My second question is probably for the Department. Is there a stock of vaccines that may not be used?

The Chairperson:

That is not the direct responsibility of the Public Health Agency.

Dr Deeny:

That is correct, but can the witnesses answer my first question?

Dr Harper:

The Joint Committee on Vaccination and Immunisation (JCVI) advises the UK Government on vaccine policy. The committee will examine such issues for next year and beyond. The policy also depends on the type of seasonal flu virus that emerges.

Dr Deeny:

This week, a lady asked me whether she should have her child vaccinated for swine flu. She was asking because reports indicate that the virus has died out. People involved in primary care will need to be advised on how to answer such questions.

Dr Harper:

A decision on vaccination still comes down to an individual assessment of risk versus benefit. I can understand why, in light of the figures, a mother may feel that she is taking more of a risk by getting her child vaccinated. However, the evidence on the safety of the swine flu vaccine is unequivocal; millions of doses of the vaccine have been given worldwide, and it is very safe. At the same time, if parents feel that the threat has gone away, it is their choice whether to get their children vaccinated. A patient's choice is as much the issue as giving advice directly to GPs.

The Chairperson:

It is reassuring to hear that all the trends are going in the right direction. Much has been learned about how to deal with such pandemics, and let us hope that the downward trend continues until there is no evidence of any swine flu in Northern Ireland. Thank you very much.