Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Capital Priorities and 2011-12 Resource Budget

15 June 2011

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Michaela Boyle
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Mr Sam Gardiner
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

Mr John Cole	)	
Ms Catherine Daly	)	Department of Health, Social Services and Public Safety
Dr Andrew McCormick	)	
Mr Peter Toogood	)	

The Chairperson:

The Committee has received a briefing paper from the Department of Health, Social Services and Public Safety (DHSSPS) and a summary of the McKinsey report. The briefing paper was received only this morning at 11.30 am. We had hoped to have it before the weekend so that members could have time to consider it. I suggest that we take the briefing today but that we ask the officials to come back on 29 June, when we have had time to consider the issues and can

engage in a more thorough question-and-answer session.

I have read through the briefing paper, and I am disappointed that it is a wee bit light on some of the detail that we would have expected at this stage. I am a bit concerned about paragraphs 7 and 8, and paragraph 8 in particular, which states:

"We also recommend that you consider and decide on the extent to which you wish to require that the actions Trusts are proposing to contain costs in 2011-12 are subject to specific Ministerial approval. There are many specific decisions some of which will be controversial."

As I read that, Andrew, it appeared to me that this may be a cut-and-paste from the Minister's first day brief. It took quite a while to get this paper through, and we did not get enough time to scrutinise it fully. Now, after some scrutiny, it looks as if it is a patch-up of other papers that have been prepared for other people. We recognise the fact that the Minister has a level of detail that we do not have, but we asked for an evidence session on the capital priorities and 2011-12 resource budget, and we need a level of information that is not in the paper.

You are very welcome, and I do not mean to start off by being so negative, but this really is not good enough. We got an undertaking from the Department that the relationship with the Committee would be different, and we expect a better level of information. I know that if I were to go to the Committee for Agriculture and Rural Development with something such as this, I would be chased. It is not fair to members. Some of us are new to the Committee and do not have the institutional memory that others have. We have not been given enough information to enable us to do our job properly, and I am disappointed in the level of detail in the paper.

Before you start, Andrew, we asked the Minister when he was here last week to brief us on the Department's priorities for action paper. We understand that that is the template for commissioning services for this year. It is now June, and if that paper is not prepared or is not ready, how are trusts managing to commission services and why are we operating halfway through the year without that guidance? I am a bit concerned, and I would like some clarity.

We did not receive a clear and concise answer from the Minister last week. We have a very important job to do, and we need as much information as we can get to do it. We need to know the Minister's thinking on the delivery of services. We know that there are difficult issues that need to be dealt with. People expect us to ask the questions that they would like to ask. Would you like to kick off, Andrew, and we will take it from there?

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):
Obviously, the first thing to do is to apologise without reservation to the Committee for the delay in getting the briefing paper to you. I take on board entirely the points that you made about that, and I thank you for not chasing us. We owe you significantly on this issue today.

The Chairperson:
You do.

Dr McCormick:
I undertake to do better for next time. I am sorry that the value of this afternoon's session is limited. I hope that we can understand your questions more fully and make sure that, when we come back at the end of the month, we have made thorough preparation for that meeting. We will endeavour to get as much information as possible to you well in advance of the Friday before that meeting on Wednesday 29 June. We will work carefully with the Minister on what he wants us to release and what he wants us to say. That is part of the process, as you are well aware, but we apologise entirely for what has happened today. We will do our very best this afternoon to expand on the information that you have and to answer your questions.

I will say a little bit by way of scene-setting. I hope that I will draw out some of the points that are in the paper. The overarching point is that we are working with the Minister and the team to receive and establish clarity on decisions, but it is still early days. They are not easy issues. The dilemma that we face about resolving the financial position of the current year and beyond is complex. We have a clear direction from the Minister to do better in delivering options for savings and ways to make better use of money. We are working with the Minister, his special adviser and the Assembly Private Secretary, who is a former member of the Committee. All that team are working with us in a careful way to establish options. The Minister is keen for issues to be resolved, but the position is complex and detailed. The key point is that whatever is decided will have significant consequences in the real world, and, therefore, we want to provide the Minister and the Committee with advice and assistance so that the best decisions are made. Those decisions will not be easy. There will be lots of difficult issues to resolve, but the objective has to be the best available decisions.

I will say a little about the current and capital budget and about the three reviews: the performance and efficiency delivery unit (PEDU), the McKinsey report and the Appleby report. I

will cover those briefly, and you will have as much time as possible to ask questions. As the Minister said last week, we had a settlement for 2010-11 to 2014-15 that showed an 8% increase across that four-year period. Everybody in the Department recognises the wider context in that the Department of Finance and Personnel (DFP) and the Executive provided the best they judged available for other services. We recognise the fact that it is a more favourable settlement than many other Departments. It is not that far away from the English settlement for health, and we are facing a very severe public expenditure context. We accept the responsibility to do the very best that we can to work with that, and we recognise the priority that it has been given.

However, we face ongoing cost increases. Put simply: over the long term, we face three 2% increases a year here and in other jurisdictions. That adds up to a pressure that rises by about 6% a year. It is 2% for underlying costs, such as pay; 2% for demography and the way in which the population changes according, for example, to age; and 2% for residual demand. That residual demand is new demand presenting where the service can provide better drugs, better treatments or better therapies. That is the long-term trend in this and other jurisdictions. That is an important point that we took from McKinsey's work. It gave us an evidence base that we were not dreaming up that trend of expenditure, or trend of costs, but that he had had that experience in his work with other jurisdictions.

McKinsey worked with the Welsh Assembly Government and several strategic health authorities in England, and the broad trend of evidence of our situation is similar to their experience. That led to the view that we were also facing rising costs. If nothing is done and we keep going as we are and meet demand in the same proportion as now, costs will rise and take us to a funding gap of £300 million in 2011-12 and rise to about £800 million in 2014-15. That is based on recognising those three main cost drivers: pay and general inflation; demography and an ageing population, along with other factors; and residual demand. To cope with that, a significant change programme is required to deliver more efficient and effective services.

We recognise that we are in a context that has all the benefits of a National Health Service (NHS) model. Fundamentally, it is a tax-funded model, which means that taxpayers expect costs to be contained and resources to be used in the best possible way. We have drawn on evidence from a range of sources. The McKinsey report is by no means the only source for our consideration of the scope to make change in a manageable and sensible way.

I need to separate the two distinct time frames. I will return to the longer term later, but, for 2011-12, we have to deal with the short-term cash issue. We have been working carefully with colleagues throughout the health and social care sector, especially the Health and Social Care Board, to establish the minimum level of funding that would allow us to deal with our inescapable pressures and statutory obligations. That means maintaining services at an acceptable level and setting aside things that are highly desirable but, to a degree, discretionary. As our briefing paper explains, if we remove all those and do only what we consider essential to maintaining existing services and meeting essential demands, we arrive at an in-year shortfall, at the start of this year, of about £177 million. Precise figures can be debated in all sorts of ways, and I assure you that we are having that debate with the Minister and DFP. That is part of what keeps us extremely preoccupied at present.

More important are the consequences of change for services and the public, and that is what should drive the decision-making process. We must try to put together the best available combination of decisions, because many different aspects are involved. One reason for our not yet having a priorities for action document approved by the Minister is that the work is ongoing as we try to establish those priorities. There is no point in setting targets and priorities for the service if the resources are not available or if resourcing is an issue. By no means is everything in the priorities for action all about money, but there are important links, so it is best to establish a package.

The service has many ongoing standards and requirements, and it continues to work towards those. The absence of priorities for action does not mean that the service wholly lacks direction. On the contrary, we are holding to plenty of standards. However, a new judgement is required by the Minister. Some issues may go to the Executive, and many issues will be aired in Committee. Until that broader position is clearer, the Minister is not ready to publish the priorities for action. Indeed, he could choose to adopt a different title or style. The Health and Social Care (Reform) Act (Northern Ireland) 2009 requires a commissioning direction from the Department, and we are working on that as part of the overall package. A commissioning direction is a formal statement by the Department on behalf of the Minister, and it outlines to the Health and Social Care Board and the Public Health Agency what the commissioning plan for 2011-12 should contain. It is important that we try to get some movement on that this month so that there is some clarity. I suspect that the scale of issues that we face means that we may not achieve full resolution until September. That will become clear as we come to the PEDU issue in a moment.

In the briefing paper, we tried to provide a broad indication of some measures. We need to probe those this afternoon and provide the Committee with more detail at our next meeting, and we will gladly do so. The kind of area in which we seek to close the gap is that of the pharmaceuticals budget, as discussed many times by the previous Committee. We believe that further steps can be taken: better management of medicines; further increases in generic prescribing; further action to reduce waste; the removal of discretionary medicine from the prescribing list; and encouraging the better use of medicines throughout the service and by the public. There are continued opportunities to make savings. We continue to bear down on administration costs and overheads for the Department and the arm's-length bodies, making sure that they are prioritised and that funds are used as effectively as possible.

The funding gap was calculated by comparing figures for the 2010-11 financial year with what would have been needed for 2011-12, based on the same service patterns. Given that some things have not started because expenditure that should have happened has not been authorised, the gap has closed a bit. That is helpful financially but negative for service delivery, because developments that should have been in place and recruitment that should have started have not. In due course, we will bring you more details on that.

A lot of work is going on to reduce the £177 million cash gap by as much as possible. Further consideration needs to be given to that with the Minister and DFP, and we are working very hard on the issue. Alongside that, it is important that the trusts complete their task of achieving a recurrent delivery of efficiency savings, which they were obliged to do in 2007-2010. Although there is still work to be done to secure recurrent efficiency savings across the trusts, we are confident that they will deliver them. The trusts' task is very clear: they are working to secure between £60 million and £80 million of savings. However, that will not close the gap; it just involves them making use of the resources that they have anyway. So that is for them to do. It involves managing vacancies and the workforce. A vacancy control policy, which was regarded as non-recurrent, was in place in 2010-11. Making it recurrent means being clear about which vacancies can be filled permanently. That requires careful and complex service management.

The trusts have also submitted significant plans to manage service redesign and to move as much as possible from a residential to a domiciliary care model, known as the reablement model, which is important for giving elderly people the way of life that they want and for fulfilling our

strategic desire to have as many people as possible able to maintain their independence by being cared for in their own home. That means that we need to make adequate provision for domiciliary care, which is why that continued pressure is difficult to manage. Nevertheless, it is a key aspect of ensuring that change is driven by the best interests of the population and not just by cost issues.

Important work is also going on in procurement to ensure the standardisation of supplier contracts at regional level. At a service-wide level, DFP and the Health and Social Care Board are keen for negotiations with suppliers to secure the best possible procurement terms in the present straitened circumstances. Consideration is being given to reasonable and manageable client contributions — charges for services — including car parking and meals. In considering those, we must make sure that we have something that is fair and standardised. Although such charges may raise a little additional money, we have to be sensitive to the interests of patients. So there is a lot to be done, and we are still working on it.

As we look towards the longer term — the short term has to be about reducing cash — there are many excellent ideas to improve productivity, but, if they do not release cash, they will not close the financial gap that we face in 2010-11, which is a big issue.

There are five broad themes. I will discuss the themes in order of ease of doing them, which is not necessarily the order of their scale or impact. The most straightforward one, which is talked about a lot, is to bear down further on improving efficiency in order to release cash back. However, it is harder to get large returns from that, because so much has been invested in it in the past three to four years. Nevertheless, the Department, the board and the trusts have given an undertaking to endeavour to find further efficiencies that will release resources.

As we move forward, service reconfiguration is a big theme. It is about changing the way in which services are delivered, the pattern of services, the hospital configuration, and the nature of social care and how it is delivered to maximise quality. It is important that that theme be led mainly by providing the highest quality of services. That is the right thing to do, and professional leaders are totally committed to it. It is important that all those service changes are informed and led, as far as possible, by clinical social care from other professional leaders. That is absolutely central.

The third theme is to examine further options for charging, which depends on political acceptability. My point is this: let us compare the political acceptability of asking for some modest, reasonable charges from people who can afford to pay versus the service consequences of other options. The judgement may be that it is possible to find a way through without making additional charges, but that is a judgement for the Minister. The issue needs to be examined in that context.

The fourth broad theme is wider, more controversial policy change, which is sensitive territory. There is a strong commitment, for example, to maintain pay parity with the rest of the UK. In theory, Ministers could consider that. There is an expectation, particularly among the unions, that it will be maintained because we have a UK-wide labour market in most of the health professions, not to mention the fact that we have pay comparisons with the South. That issue needs to be looked at carefully. Angels fear to tread on that one, but it is on the list of issues that needs to be considered.

The fifth and final theme is, of course, about seeking additional funding from DFP. As you are well aware, it is not as though DFP is sitting on unallocated millions; that is not the case. We know that that creates an opportunity cost for the Executive in other ways.

Those are the issues under five generic headings, and I think that we all fear to tread on most of them. The problem is that the easy options are much more limited. A further important point is that any solutions that we have found for the current year already include about £100 million of items that cannot be repeated. For example, DFP permitted a switch from non-cash to cash allocation. There is no reason to believe that that can be repeated, which means that, when it comes to 2012-13 and beyond, we need to make the kinds of changes that are recurrent. It means that this oil tanker really has to change course significantly. There is a need for significant service redesign and change. That is the real difficulty in making sensible plans for 2012-13 onwards. That is why there is a case for looking at what we do radically and for going forward with very few holds barred.

On the capital side, the settlement across the four-year period is £851 million. Some £263 million is already contractually committed to projects that are under way. Indeed, that figure could be £300 million if ICT contractual commitments are counted in. We also need £348 million of that £851 million for ongoing annual commitments, such as ongoing capital to keep

existing facilities working properly and to renew things; that is simply an ongoing demand. So we have only £240 million over four years for new projects, which means difficult decisions in the face of such a challenging set of issues across the estate. We also need to think hard about some of the service reconfiguration that we talked about and whether it would be best facilitated by new capital investment. That is a serious dilemma.

We need to continue to upgrade the major acute sites, which are major capital projects. There are, as everyone is well aware, serious deficiencies in the existing infrastructure. A big part of the strategy is to try to deliver more services in a primary or community care setting, and to make that work properly requires some investment in health and care centres. There have already been some good projects, and the programme is ambitious, but we have to limit that according to the resources available.

Mental health and mental disability facilities remain, in many cases, in serious need of upgrading, and we need to look at that. Objectively speaking, we are underinvested in ICT, and some of the efficiency improvements that we need to make would be much better achieved if we could upgrade some of the existing systems and invest in new systems. John Cole can take more detailed questions on those matters; there is a lot more that we can say in detail.

We estimate that, to do a proper job of providing capital investment for the health estate and health and social care facilities, around £5 billion over 10 years would be a more genuine measure of need. That is not available at present, so we need to look at priorities in a challenging way and to think creatively about whether there are any options for alternative means of funding. I have been involved with that in other Departments, but it is not a magic bullet. There is every reason to explore options, but it would be wrong to raise expectations of quick solutions. We have to continue to look at that carefully and at the relationship between capital and current budgets. There are additional costs on the current side when a new building is opened, usually because the facility is a significant improvement on the past, not to mention the fact that there are inevitable automatic bills for rates and services.

I will now turn to the reviews. We are very close to being ready to release terms of reference for PEDU; that matter is being discussed by the Budget review group today. That will start very soon, and some preliminary work has already been done. We recognise the fact that we have to build on the McKinsey report. It is important to emphasise that the McKinsey project provides

options and evidence. It is a menu from which choices can be drawn; it is by no means a simple blueprint. It is not an all-or-nothing approach. It comprises a range of themes, some of which, as the Minister said, he would consider, and some of which he would rule out. PEDU will examine that and then ask whether there are things that the Department has missed, that McKinsey did not bring out or that, through evidence-based good practice, could apply here.

In that situation, PEDU will give us access to a range of other inputs and advice and will then move to help with implementation. It is all very well to have ideas as to what might be done, but making it happen in practical terms is a big management task, which has been part of the challenge. McKinsey is one body of work that will inform the advice and decisions in light of the PEDU review and the way in which the Minister will go on the issues. We are also grateful to John Appleby for doing what he called a "rapid review" of his 2005 work. What John produced shows starkly the scale of the challenge that we face and gives important signals to the areas to which we need to pay attention. We are aware of that, and we need to look at productivity issues, recognising that they are not separate from service configuration issues. A lot of evidence is available, so it is a matter of marshalling it, drawing it down to a decision-making process and finding the best way to do that while ensuring that all we do in planning and management is in the public interest and provides the highest quality of service.

I hope that that is helpful in setting the scene, and I repeat the apology for the bad handling of things this morning.

The Chairperson:

Thanks for that, Andrew. I suppose that that will probably generate as many questions as answers. You highlighted the list of things to do, but you did not give us an idea of when they will be done. You said that the Department's priorities for action are not ready. Has a commissioning direction for 2011-12 been drawn up yet, and when will we know the Minister's thinking on the matter?

I wondered whether you would mention the pay parity issue, because we are all keen for it to be considered. Some areas in which you are hoping to find money to go towards the £177 million shortfall include pharmacy efficiencies, which seem to account for a big whack of the savings. For example, multiple prescriptions are to be cut by over 50%. At times, there seems to be quite a clumsy approach. The issue of fewer hospital sites is in the McKinsey report, but you did not

give us an indication of the Minister's thinking on that. Has the Minister come to a decision on any of those issues? There is still not enough information for us to have a discussion about them. As I said, there are more questions than answers.

Mr Wells:

At the end of your contribution, Andrew, I felt like saying, "apart from that, everything is fine". Your contribution was really challenging. I wish to check a couple of things. First, in February, when the Minister of Finance and Personnel was discussing the Budget in the Assembly, he said that if PEDU discovered unavoidable costs that you simply had to incur and that you had done all that you could on efficiency savings, top-slicing would be applied to the other 10 Departments and you would get the money. Is that still your understanding of the situation?

Dr McCormick:

Yes, he did say that.

Mr Wells:

So you are saying that there could be additional resources from DFP and the Executive. Implicit in that is, if you prove that you have gone as far as you can, you will get the money. At least you have that parachute.

Dr McCormick:

It exists. Obviously, from the point of view of the ministerial team, it is a last resort, because it would mean disrupting the Budget, so no one wants to go there. It is good that it was said, but our responsibility is to do our best to avoid it being necessary, and we accept that task. It is challenging, and last week the Minister said that he could see himself bidding for additional resources later in the year, but the timetable for a resolution is likely to be September. Our position is that we are opening our books fully to DFP, and, if we have missed things, we will be pleased to have been proved wrong. If the situation is not as gloomy as I have been saying it is, it will be good news all round. Whatever about that, our responsibility is to get on and deliver as much efficiency and as many cost savings as is reasonably possible at present. I have written to all the health and social care chief executives to ask for that, and I am in regular contact with them about what can be done. We need to find a resolution. I understand that it is late in the year to be doing this and that it is not ideal. However, we have to work from where we are, not from where we want to be.

Mr Wells:

I think that there will be enormous resistance in the Assembly to any form of charging, particularly if that takes us out of line with the rest of UK, because, once that hornets' nest is opened and people start to go down the slippery slope of charging, it is in breach of the fundamental principle on which healthcare has been based since Beveridge of ensuring that it is free at the point of demand and need. I think that the "thin edge of the wedge" argument will apply. People will be desperately hostile to it.

I come to the issue of significant cash-releasing efficiency measures. My understanding is that, at present, a GP has a choice about whether to prescribe either the all-singing, all-dancing, Glaxo-branded product at £26 or the cheap generic version at 90p. At present, it is illegal for a pharmacist not to prescribe what is on the script, and if that is a branded product, he or she has to prescribe it to the patient.

Norman Morrow was a Committee witness just before the election, and he said that there is no reason why the Department could not simply say that, from now on, every GP shall prescribe generic versions, if those are available. However, people will not have that option. We know that the generic version is exactly the same chemically as the branded one and that £26 is being paid for the packet — nothing else. When people say that they feel much better after they have taken a branded product, we know that that is just nonsense, because a branded pill is exactly the same as a generic one. It might be a different colour, but it is the same pill.

Why do you not introduce that immediately and release £61 million by simply issuing instructions, through Norman, to all pharmacists and GPs stating that, from 1 July, they will prescribe only generic drugs, if those are available, and that if they decide to prescribe a branded product, the cost of that will come out of their budget? We understand that that would save £61 million immediately, which is a significant proportion of what you are looking for, with no impact whatsoever on the patient.

The Chairperson:

Before you answer that, Andrew, I want to say that I raised that issue with the Minister a couple of weeks ago. Jim has raised it on the basis of GPs and pharmacies. However, acute care also uses branded products, and there are considerably more savings to be made there. So when you

answer that question, will you refer to all of them, not just GPs?

Dr McCormick:

One key step is to adopt what is called a formulary, which is a specification of what can be prescribed, and apply that to secondary and primary care. We want something that is Northern Ireland-wide; that is exactly the point.

The only valid argument for sometimes using non-generic medicines is the safety of a patient such as an elderly person who takes several types of medication and is very familiar with the colour of one. In that case, there may be a reason to maintain what a patient is used to. However, we are redoubling efforts to ensure that there is the maximum possible generic prescribing.

We are looking for a further £30 million a year. I do not recognise that £61 million would be immediately available. I will need to double-check that and speak to Norman further about your point. The advice that I have is that £61 million would not be immediately available. However, we think that we can get a further £30 million a year. That is part of how we will close the gap in 2011-12, and further efforts to increase the proportion of generic prescribing will be a big part of it. The aim is to develop and apply a formulary. The approach that Norman has led over the past number of years has been to ensure that the change is as much about quality as it is about the safety of the way in which medicines are managed by looking at the role of GPs, pharmacists and secondary care and bringing all the professionals together. I do not deny that there is room for a more direct approach. However, I do not think that it is as simple as you are making out. We will certainly look again at the issue and further pursue it with Norman about exactly what to do. We need to do the very best that we can on this issue.

Mr Wells:

I concur with the Chair: you have direct control over pharmacists in hospitals and could, therefore, issue instructions immediately. By the way, that figure of £61 million came from an extrapolation of the Castlederg pilot project, which saved £331,000 in five weeks. If every GP surgery adopted the same policy, there would be an estimated saving of £61 million. It strikes me that that is one of lowest forms of hanging fruit that you have.

There was an agreement between the Department and the Minister of Finance and Personnel that you would have total flexibility within your budgets in return for having the first £20 million

call on the monitoring round money in June. You have lost that now, and you do not have an automatic first call. Does that not open up the possibility that you will have calls on the next three rounds? I presume that you will be bidding very heavily in those three rounds for extra cash. There is potential for extra cash to come in through that source, which you did not have.

I will turn to the issue of allocating money from capital to recurring. I thought that part of that deal was that you did not have to get DFP permission to move money between the two pockets. You said that there is £100 million, once off, in the present budget, which you will not have next year. What is to stop you continuing to move money from capital to resource in the next three years to try to make up that gap?

Dr McCormick:

There are several issues there. DFP will still be presuming strongly against us bidding. If the circumstances and the settlement were normal, the two sides of the coin would be flexibility for the Department and no right to bid in any monitoring round. In the present situation, because of the Finance Minister's February statement to which you referred, there is certainly a possibility. As is the case with all Departments, we are obliged to bid only when it is essential. Catherine will explain the restrictions on capital to recurrent.

Ms Catherine Daly (Department of Health, Social Services and Public Safety):

There is no flexibility to move between capital and recurrent expenditure. At the stage of the Budget settlement, Departments were offered the opportunity to identify whether they preferred to move some money from capital to recurrent or, indeed, vice versa. The Executive considered that in the context of the overall block position. Those budgets are settled now, and in that context, there is no flexibility to move between recurrent and capital.

Dr McCormick:

This is a long-term issue for the public sector, because the tendency in all my years in DFP in the 1980s — the classic way to resolve short-term pressures on the resource budget — was always to raid the capital side. The consequence of that for the public sector is that we have had inadequate infrastructure investment. The Executive, and senior Ministers in particular, were very determined, in the Budget round that has just finished, to examine the impact of capital investment on the economy. In rebalancing the economy, they wanted to make sure that, if anything, the pressure was to move money from current to capital. That was the trend in the

Office of the First Minister and deputy First Minister (OFMDFM) and DFP; that is what the centre wanted. Given the difficulties that we had looking at 2011-12, we were permitted to move £19 million from capital to recurrent. However, as Catherine said, that was a one-off, and we cannot do that again. That is a Treasury control that is designed to avoid short-termism.

The Chairperson:

I want to go back to the previous point, Andrew. Catherine said that there was no flexibility. There will be no appetite, even, for top-slicing. I would be very surprised if PEDU came back and said that everything that can be done has been done and that it recommends top-slicing. The fact is that changes could be made immediately that would have a significant savings impact on the Health Department's budget, but they have not yet been made. Why not? For example, why are savings on generic drugs not being made now across acute and primary services so that we do not have to look at other things that you have described as unpalatable?

Dr McCormick:

We are determined to do all that is possible on the issue of generic drugs. I will come back to you with precise numbers in that regard. We will prepare the ground so that we can focus on that issue later this month. Our undertaking is to do all that is possible with the pharmacy budget because, as you say, it is an area in which there is a cost saving without service change or risk to patients. However, it needs to be managed because it is not simply a matter of writing a letter and making it happen. I have asked that question many times in the past year, and we are adopting an approach that will involve several changes, including changes to the formulary, further guidance to prescribers and further partnership between prescribers and dispensers so that we involve professionals in their different roles. We want to secure the best possible outcome, and I will come back to you with more detail on that.

The Chairperson:

I am a wee bit perplexed. You sometimes simply have to take the bull by the horns and tell people that that is what you intend to do from now on. I am surprised that that has not been done. Andrew, you said that you have been asking questions. What answers have you been getting? It seems to me a wee bit strange that savings are sitting there ready to be made. Castlederg can lead the way on this. Why is it taking so long for the Department to come in behind it? It sounds as if there is a will to do it if people are encouraged rather than making it mandatory. At the same time, if people are not doing it, making generic prescribing mandatory is not unpalatable to those

around this table. Given the contributions that I have heard from the Minister, I am surprised that something has not been done about this already. What is the problem?

Ms Daly:

A number of efficiencies were delivered in the financial year that has just ended. A big chunk of those efficiencies were in pharmacy. The full-year effect of the changes that had already been put in place to deliver those efficiencies was £40 million. In our discussions with the board, it advised us that there is scope to deliver a further £30 million, so that would give us an overall package of £70 million. I am not giving you the detail here of how that is made up, but, as Andrew said, there are complexities, and it is not straightforward. If it were helpful, I suggest that we give you a paper that sets out the £40 million that is being delivered in full this year as a result of the actions that are already in place and the further actions that are proposed, which we will be discussing with the Minister, to deliver that additional £30 million. We can set that in the context of the overall pharmacy budget, because it bears consideration on its own. It is quite a complex area.

The Chairperson:

We would welcome the paper, Catherine. I do not want to labour the point, but the pharmacy efficiencies that you identified are to do with cutting back on the cost per prescription, and multiple prescriptions, as I said, are to be cut by over 50%. We saw what happened when the card account system came into post offices, for example, and post offices lost a considerable amount of their revenue because one transaction was counted rather than two, three, four or whatever. If that is the case, and multiple prescription charges are reduced to that extent, I can see that that will have a massive impact on rural pharmacies. Pharmacists in small rural towns and villages provide not just a dispensary but a primary care service with blood pressure checks, and so forth. The valuable service that they provide in isolated rural communities will probably no longer be available. Finding a good chunk of efficiencies in that area will have a knock-on effect on services provided to vulnerable people, and I would be very concerned about that.

Dr McCormick:

That is partly why the entire issue has to be carefully managed. Bearing those points in mind, it is about making sure that a patient's interests come first. It is a matter of ensuring that the professionals are able to fulfil that responsibility, in which respect they have the right and the responsibility to exercise their judgement. I always hesitate to instruct professionals what to do.

It is vital to ensure that generic prescribing is the norm where possible, which is what we do, and that we monitor professionals. We need some monitoring of information so that when a practice is not meeting normal behaviour on generic prescribing — when the proportion is not right — there is a reasonable challenge. Again, clinicians need to have, in a patient's interest, the right to make clinical judgements.

Mr Wells:

Sorry, Andrew, I am really getting quite angry. Take the scenario of two GPs working beside each other: one GP prescribes a branded product at £26; and the second GP, dealing with a patient with exactly the same symptoms, prescribes a 90p alternative. Why should we allow those GPs to have that discretion?

Dr McCormick:

I am sorry. We are not allowing that as the norm. The expectation will be that GPs prescribe generically. The effect of the formulary will be to take many expensive items off the permitted list, and we will end up with something that is more constrained. However, there will be times when a clinician will have good reason to exercise that judgement, and not only will that be defensible but it will be the right thing to do.

We need to bear down on the issue as much as we can. I am not disagreeing with your point, but I do not think that it is as simple as writing a single instruction. The issue needs to be managed properly to ensure that professionals have an input to the process. After that, we can take the issue forward. There will be significant further savings, and, as you say, we want to build on the successful work in the Western Health and Social Care Trust area, which was an important project. We also recognise the fact that many things are not —

The Chairperson:

We have the gist of it. John wants to come in on that point.

Mr McCallister:

I have a quick comment on what Jim and you have been saying, Chair. We accept that there have been some difficulties, and progress has been made. Over the past four or five years, generic prescribing has been lifted by a reasonable percentage, but we are still 5% or 6% behind England. That is probably the Committee's concern. You say that we are taking the matter as far as we

can, and there can be good reasons for that. A few months ago, Norman Morrow told the Committee that there is a limit to where we can push the issue of generic prescribing. However, at a rough guesstimate, we are still about 10% below that, so there are a lot of savings to be made from it.

Dr McCormick:

We will do our very best.

The Chairperson:

Andrew, you made a point about not wanting to tell professionals what to do. I think that professionals are looking to the Department for guidance and support. I welcomed the Minister's comments at the Nurse of the Year awards on Thursday night. He said that he was happy to take ideas and suggestions from health professionals about where savings could be made. I am sure that I am not on my own. I have listened to people who work as health professionals screaming about knowing that there are obvious savings to be made and nobody taking decisions on making those savings. They can see things that are a pointless waste of expenditure, and they can see things that need to be done urgently but which are not being funded. I hear people's frustration.

On the BBC last night, a health professional said that although the budget is ring-fenced, the effects are not evident. People with mental health problems have drugs thrown at them constantly, when what they need is counselling and other therapies that can help them to deal with their depression or mental health issue. There is a real need to take the system and shake it, but that does not seem to be happening. It is frustrating. We hear ideas and suggestions about where savings can be made, but nothing is happening. Why not?

Dr McCormick:

This needs to be done. There are things that need to be done.

The Chairperson:

So do it. Andrew, you are the permanent secretary, and the Minister has said that he is up for this: so do it.

Dr McCormick:

In many respects, those decisions are needed. That is part of what is needed. There is also a need

for clear management accountability. That is part of what is necessary to make that happen. We need to make sure that the system is working effectively, which is where the management side comes into it. We must have clarity, which has not always been the case over the past number of years. One reason why the review of public administration mattered so much was the need to secure a more streamlined and effective management system. To me, the Nurse of the Year event has always been a source at which to hear ideas in the system about to how to save money. Many times, I have talked to people and asked them how those savings can be reproduced. Often, an idea works in one context because there is an individual leader in the front line, such as the Donna Keenans of this world who have done something and made it happen.

The Chairperson:

They did that because they had support from their managers and the people around them — the team. It takes leadership and vision from individuals, but individuals work as part of a team. Therefore, if they get support from their team, their good ideas are acted on. Nevertheless, every day of the week, hundreds of good ideas are not being acted on. Why not?

Dr McCormick:

It is not easy to make that happen. Something goes wrong, and that affects the entire public sector. If this issue could be cracked, public sector management could be cracked. How do you take a good idea that works in one place and make it work across the piece? That is hard to achieve. There will be a difference of circumstance or leadership style that somehow stops it. We really need to do better on that. We need to be able to reproduce good ideas and make them work. At the moment, I am holding a series of accountability meetings, at which one of my normal questions is whether a trust is applying evidence-based good practice. If there is evidence that something works, what is the attitude to it? Are the trusts applying it? I need to keep that pressure on constantly. I am sorry that it is not working as well as it should. We need to do better.

The Chairperson:

Nowhere else in the public sector has received the budget increase that health has received. Indeed, a number of weeks ago, when we met the Minister, he pointed out that his budget was double that of Bairbre de Brún's in 2001, yet the population is not seeing the benefit of that. There has not been a doubling in standards of care. There is good practice; for example, I understand that the Western Trust received an award in England last week. So good things are

happening. I am keen that we work with the Department and that we give praise and plaudits to the people who are working well. I do not want only negative stories to come from the Committee. However, at the same time, we get very frustrated by the fact that we seem to be hitting a brick wall on this one.

We heard that we need £177 million this year and about the issues that are coming up in the future. I have still not heard from where the savings will come. As I said, the other Ministers around the Executive table will not want to take another whack out of their budgets because the Health Department cannot get its act together.

Does anybody else want to come in? You are all very quiet today, for a change.

Mr McCarthy:

I want to talk about provision for mental health and learning disabilities, which you mentioned. Are we on target to introduce the recommendations in the Bamford report? Do you envisage blockages along the way, because that would be the last thing that we would want? We want to make sure that mental health and learning disabilities are tackled in accordance with the Bamford report and the 'Equal Lives' report.

Dr McCormick:

Like everything else at the moment, it is very challenging. We have to undertake to do the best that is possible. Again, the situation that we face is that some expenditure that probably should have been mobilised in 2011-12 has been delayed. The priority in the last spending review period, 2007-2010, was to make it the top service development priority, and significant investment was to go into it. I share the frustration that more was not possible. We now face serious choices. The major theme of Bamford is to secure the improvement of services in a community context, and it would be an indictment on society and work over decades if we were to move more slowly to a modern delivery model for mental health and learning disability services, which should be based much more in the community and much less in institutions. There is an opportunity to work with the Department for Social Development, which has an important role to play in relation to supported housing. Securing the right facilities for some clients involves joint working across Departments. However, I would not like to give an undertaking that we are on track for that, because this is a very challenging context. It is one of those areas where, in considering what is possible, we have to judge consequences and form a

view on the different priorities, and that is immensely challenging.

Mr McCarthy:

I am disappointed to hear that. The bottom line is that Bamford has been on the go since 2005, and it is a 10-year review. It is very worrying to see gaps appearing. We should try to keep it to the top of our agenda so that mental health and learning disability services are not lost, as has happened in the past.

The Chairperson:

Supplementary to that point, Kieran, I know that John and Peter have not had much of an input so far, but there are issues. I would not like money to be shifted across from capital to recurrent because that is a sticking-plaster approach. We need a better way of dealing with financial pressures rather than raiding the capital coffers.

In Dungannon, in my constituency, the old sanatorium houses a facility for young people with special needs. It is a horrible building. There was a recommendation — I do not know how many years ago — for a new purpose-built facility. However, those people are still there, and it is depressing that some of our most vulnerable adults and young people are being dumped in some horrible facilities. We really need more of a will to invest in our vulnerable people and in ensuring that they get the support that they deserve. They have been patient, but that patience has run out. We will hear those kinds of complaints in our constituencies by people who are just fed up waiting for buildings that they were promised years ago.

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

I can but concur with your comments. Much of the estate, particularly in relation to the Cinderella mental health, learning disability and some children's facilities, is a real disgrace, to be honest. It is a constant battle to get the capital to invest in them and to prioritise that spending. Every trust that we go to has a huge list. The briefing paper states that we need an estimated £5 billion to refresh and modernise the entire estate.

We are trying to share the money among the different programmes of care. I know that it does not solve the specific problem to which you refer, but in our current programme, we have a new centralised Belfast psychiatric unit to replace some of the terrible accommodation that is out there at the moment. We are adding a further extension to the Bluestone psychiatric unit to try to move

from some poor accommodation. We have the Old Sea House development in Belfast, which, in line with Bamford's ideas, provides care in the community as we try to move away from the need to put patients into large acute psychiatric units unless it is absolutely necessary to do so. Those schemes will cost some £30 million or £40 million between them, so they are costly. Over the next four years, as Andrew told you, we have £240 million in total for new schemes. The four schemes that I mentioned account for £40 million or £50 million of that.

The Chairperson:

Where are they?

Mr Cole:

There is a Belfast psychiatric unit in the centre to try to rationalise Knockbracken, the Mater Hospital and Windsor House, which, as you know, is in very poor condition. The Bluestone unit is in Craigavon, and we have another residential unit in Belfast on the Shore Road. However, we are also building a new facility at Gransha in Derry, which is the first of those to go ahead. So we are trying to spread it geographically as well as financially. It is a pressure.

We can do only what we can with what we have to spend. Every penny that we get in capital in health is spent in the year in which we get it. We are one of the most efficient spending organisations. The problem is that we do not have enough money. We have been unable to deliver in our programme major facilities such as the children's hospital. That is a regional facility to serve all the children of the Province and would cost approximately £200 million. That is despite the fact that the Assembly and many of the members around the table have spoken in support of it.

The Chairperson:

Including me.

Mr Cole:

We still do not have the money to do that. Our programme does not support what we need because of years and years of underinvestment until about 2001 or 2002, when we started to scale up. However, for the previous 30 or 40 years, we invested about £50 million a year as opposed to our level of current need. We assessed that in recent exercises, and we estimate that we need about £5,000 million to bring things up to scratch, but even that amount would not deal with

everything. We must remember that equipment, pandemic flu vaccines, IT, ambulances and fire engines come out of the capital budget every year before we start to get the money for new capital.

The Chairperson:

That brings me back again to the point that if inefficiencies were driven out, there would be more money for all those things.

Mr McCallister:

You will struggle with all the mental health issues. There was a debate on the radio this morning about mental health services for prisoners. The South Eastern Health and Social Care Trust is in charge of that. Kieran McCarthy made some points. My concern, when we talk about a reconfiguration of services, is that most people see that as cuts. They never quite believe the trusts when they are told that although the trusts are taking something away, they will build something new. It always seems as if one facility goes, but 10 years later, the new one never appears. The groups that the Chair mentioned, such as vulnerable families, find it very difficult to get services when things have been changed. Very often, those people have no voice with which to campaign and say that something is wrong or services are not being provided in their communities. That is a huge worry that I always have when things are being changed in the health structure.

Have the Department and the Minister come up with a way in which we can have a much better debate about the type of health service that we want and how much we want to spend? Jim quite rightly made a point about charging. We have all bought into the concept of a health service that is free at the point of need; that is the ethos and driving force behind our National Health Service. Charging people for missed appointments or bringing back prescription charges is hugely controversial. Is there a danger that, when you consider other policy changes, such as in pay and for other arrangements, we will lose some of our best people? I know that those people seem to be paid an awful lot of money, but is there a danger that they will move to other parts of the UK or to the Republic of Ireland? Does that have to be balanced out? How do you handle that debate? How do we get a much better debate about the type of health service that we want and can afford, with the primary focus being on outcome and services?

Dr McCormick:

That is exactly what is needed at present. We need an informed and open debate and explanation of what is possible and what is the best way to deliver services. We need to listen to what the professionals say is the best way that they can function in the service and what the public want and expect. In the present context, so much of that is about recognising the fact that resources are spread quite thinly, which means that it is harder to maintain them. It is harder to sustain groups of professionals working together if we are trying to do the same thing in too many different places.

One of things that struck me on Thursday night at the Nurse of the Year event was the bewildering number of specialty names that were mentioned. There were not two nurses mentioned throughout the evening who were doing the same specialty; their roles were very specific. That applies across medicine, nursing and the allied health professions. Each of us, when we have a need, wants to go to someone who knows exactly what needs to be done. We do not want to go to someone who has not seen a case such as ours for six months or a year. That is not good practice. However, the only way to do that effectively is to concentrate the rota of specialists in fewer places than at present. The public have not had an opportunity to hear that explained properly, to engage with or respond to the debate or to ask how we move forward. As well as the need to concentrate the specialties, there is also a need to move many more of the straightforward services to a more localised setting. Both those things have to happen at the same time. It is not about buildings —

The Chairperson:

Sorry, Andrew, we are keeping an eye on the time, and I am conscious that other members have questions. Possibly you need to be a bit more succinct. John, you got the gist of it, so we will move on.

Mr Dunne:

I am new to the Committee and still very much in the learning process. Andrew, you mentioned planned efficiencies this year of around £60 million to £80 million and that you have targets in mind for where you can make those savings. Are those inside or outside the five proposals that you mentioned today?

Dr McCormick:

They overlap with efficiencies and some service reconfigurations. Each trust will have a detailed package to put together its contribution to that issue. It is about completing the task that was set in the previous spending review, in which some savings were not settled finally on a recurrent basis. There is a need to finish that process off. It is about a combination of productivity and efficiency.

Mr Dunne:

Are those achievable?

Dr McCormick:

Those are achievable. However, the trusts are already obliged to do that simply to break even and achieve what was set as a target in 2007, so the scope to deliver a further 2%, 3% or 4% becomes more challenging. I take on board all your points; we do need to do better.

Mr Dunne:

You still have to find about £100 million.

Dr McCormick:

The £177 million is over and above what the trusts are doing.

Mr Dunne:

That is on top of that?

Dr McCormick:

Yes, it is. The point is that there are plans for £80 million in the trusts. Each trust has that responsibility and is telling us that they can do this in broad terms. That will be delivered. Part of the £177 million can be found through the best that we can do on pharmacy —

Mr Dunne:

Is that through the five points that you mentioned, or at least four of them?

Dr McCormick:

It is mainly through the first two points. That is the way forward. We can and will get the gap

down significantly. Part of the problem is that that solves only this year; next year is much worse. We are not all the way there yet, but we will do our best to endeavour to get there.

Mr Dunne:

You make the point about reductions in the scope of services offered to the public. That sounds far-reaching and drastic and brings in risk. How do you intend to pursue the matter?

Dr McCormick:

That needs to be thought out very carefully. The question that can reasonably be asked is whether the Health Service pays for interventions that are perhaps not clinically effective. We need to look at that very sensitively, because there is a pattern of expectation; I am not even going to mention examples, because whatever I mention would cause a controversy. However, there are treatments that any clinician would say are not cost-effective, and we need to examine those carefully. Some work has been done on this issue in England. We need to go through the matter carefully and thoughtfully and consult on it. We have an undertaking to the public. The whole principle of the Health Service is to provide what people really need. A hard-nosed judgement needs to be made about the effectiveness of some therapies and procedures. Again, that has to be done with great sensitivity. If a treatment is effective and worth doing, it will not be withdrawn.

Mr Dunne:

I have one last point. There is mention in the capital programme of the continued redevelopment of acute hospital sites. Does that include the Ulster Hospital in Dundonald? Is there an ongoing commitment there?

Mr Cole:

Yes, there is. The Minister has to sign off formally on the programme for the current year, but we are proceeding with those schemes as we speak. The first part of the next phase is a new £120 million ward development, the work for which is due to start on site in about 18 months' time. The design for that is ongoing. If you drive past the back of the site, you will see it being cleared for that development.

Mr Dunne:

So you are committed to that?

Mr Cole:

We are. Obviously, we are not committed until the contract is signed. However, it is our intention, within the current budget, to build that scheme, subject to the Minister's confirmation.

The Chairperson:

That was helpful, Gordon. Andrew, one of your sentences set off alarm bells with me. In clinical terms, the Health Department does things that might not be recognised — a particular drug that works, and so forth. However, helping people to lose weight and to stop smoking have a positive impact on their health and on your budgets but do not involve some company doing an evaluation on how those things work. I am just a bit wary of some of the areas that you might be going into. I am not going to quiz you on that today, but we will come back to it in a fortnight's time. We would like you to think more about where those things are going. I am a wee bit concerned that they could have an impact on vulnerable people.

This session has probably gone on a bit longer than we expected, so if anybody wants to come in, indicate now, and then I am going to wrap it up.

Mr Brady:

I want to go back to what Kieran said about the Bamford review. I have been here since 2007 and have heard a lot about Bamford at the Committee for Social Development and, particularly, at this Committee. The incidence of people, particularly young people, with mental health issues is increasing almost daily, so the gap is ever-widening between the provision of services and the demand for those services. Unless something is done fairly quickly, we will probably need another Bamford-type report. We could be sitting here in 20 years' time talking about Bamford's successor. To paraphrase a quote from Isaac Butt, although he was talking about the poor: people with mental health issues are often talked about in this house but never entertained. We talk a lot about the provision of services, but nothing happens. Supported housing is another big issue that has been addressed to a degree, but a lot more work needs to be done on that.

John talked about the appalling conditions in some services. I am going to be slightly parochial here: there is a day centre in Crossmaglen that you would probably come out of feeling more depressed than when you went in with a problem; that is the reality. The initial excuse for nothing being done there was that a site could not be found. A site was identified as far back as 2005, but nothing was done. In a recent meeting with the Southern Health and Social Care Trust,

we were told that there is nothing for that site in the capital budget for the next four years. Some people have now stopped going to the centre. In the long term, that is creating more problems and more expense for the trust. Those issues really need to be addressed rather than simply talked about.

Mr Cole:

The problem is that if we put something into the budget, we need to take something else out. The difficulties of the prioritisation process have been immense. Many of you will know about the debate around Altnagelvin, for example. Every time we put something in, we push something else out. Obviously, the Minister has to set his eyes on the final prioritisation of those issues.

We are very aware of the issue in Crossmaglen. I discussed it recently with my group, which considered how we could probably move some of those issues forward. We will look at that matter. Eventually, we will come to you with a finalised, signed-off programme from the Minister. No doubt he will reflect on your comments.

Mr Gardiner:

John, you mentioned the Bluestone unit at Craigavon. What improvements are you making there? It now has a good name after it was brought up to standard, but I guess there is more room for further improvements.

Mr Cole:

We propose to add another wing to it and remove the patients from the very poor accommodation in Armagh into the new facility, which will be efficient and beneficial to patients.

Mr Gardiner:

I welcome that. How soon will that be?

Mr Cole:

That is in the planning process.

Mr Gardiner:

Will it be next year, the year after, or when?

Mr Cole:

I do not have a date for when it will start on site. It will probably be within two years. Planning and design would be the first stage.

Mr Gardiner:

So you are just at the early stage.

Mr Cole:

It is written into the programme over the four-year period. We will commit the budget, subject, again, to the Minister's final sign-off, but it is an issue on which we are moving.

Mr Gardiner:

I want to express gratitude for the work that goes on in the Bluestone unit. It is terrific. It has a good name, and people are helped greatly in it. I welcome that extension.

Ms Boyle:

What are the proposals for Gransha Park, and is there a time frame?

Mr Cole:

Do you mean the totality of the site?

Ms Boyle:

Yes, I do.

Mr Cole:

We are building the Gransha mental health facility. We are also considering a rationalisation of the entire site to find out what areas can be released to provide resource to bring back into the system. That depends on whether we can keep the money, which is always a question, because it may go back to DFP. We propose to sell off some sites there, but we also want to retain some of our facilities. A strategic plan is in development.

The Chairperson:

John, Andrew, Catherine and Peter, we welcome the fact that you have been here today. It was a useful session. We would appreciate as early a sighting as possible of the enhanced resource

budget and capital priorities. We look forward to seeing you again in a fortnight's time to continue the conversation. Thanks a million.