Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Ministerial Briefing

8 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
Mrs Pam Lewis
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

Mr Edwin Poots	)	The Minister of Health, Social Services and Public Safety
Ms Catherine Daly	)	
Dr Michael McBride	)	Department of Health, Social Services and Public Safety
Dr Andrew McCormick	)	

The Chairperson:

Minister, you and your officials are very welcome. We appreciate your taking time to talk to the Committee. I understand that you will give a short presentation, after which I shall open the floor to questions. This is the first of a series of engagements that the Health Committee hopes to have with you over the next number of years.

Mr Edwin Poots (The Minister of Health, Social Services and Public Safety):
Thank you very much, Chair. I am happy to engage with the Committee as and when required. According to protocols that I put in place previously, on Committee days, I will try to take on reasonably flexible appointments in and around the city so that I will be available if the Committee needs me. When possible, I will give the Committee precedence.

The relationship between the Department and the Committee is important, and I want to work with you to ensure that we deliver the best possible services with the available resources. Scrutiny of the Department is essential, and I welcome it because the Committee will sometimes pick up on things of which I am not aware and, as a result, we will achieve better outcomes. I look forward to the Committee's coming forward with its own, proactive agenda and raising issues on which we may be able to assist in due course.

We face challenging times, not just in the Department but in the economy in general. As you are aware, in the context of more constrained UK public expenditure, the Executive have provided a degree of protection for health across the Budget 2010 period. That is to be welcomed. The Department of Health, Social Services and Public Safety (DHSSPS) settlement will increase spending from £4·3 billion in 2011-12 to £4·66 billion in 2014-15, which is an increase of 8%. That sounds very good, until it is set in context.

Funding levels will grow less quickly than in previous years, while demand will increase. Our Health Service faces ongoing cost pressures through a mixture of changing demographics, unit cost inflation, increased public expectations and changing technology. If we assume that the same service will be delivered in the same pattern as heretofore, the estimated shortfall against assessed need is approximately £300 million this year, rising to £800 million in 2014-15. That means that, more than ever, we must make the best possible use of every penny that DHSSPS gets. We must use resources in the right way and spend our money on the right things.

The solution to addressing the shortfall and finding more besides, so that we can do things that need to be done, will not be uniform. We need to identify solutions quickly to release cash to the front line services. In tandem with that, we need a strategic work programme to drive out inefficiencies. We must stop doing what does not work, and I will be more assertive in challenging out-of-date practices and pointing out that some of today's services are no longer fit for purpose.

We face a serious problem right now. This year, if we are to continue delivering services at the present level and meet all pressures, we have a £300 million shortfall. In the current context, it is neither feasible nor realistic to believe that a gap of that extent can be funded. It will just not happen. Therefore, my officials worked with health and social care colleagues to estimate the minimum level of funding in 2011-12 that would allow inescapable pressures and statutory obligations to be addressed. That assessment highlighted an in-year shortfall of between £150 million and £200 million, which is both material and serious. The situation needs to be addressed now. It should have been addressed sooner, but, as I have been in office for only three weeks, I could not have done soon. The situation should have been addressed prior to my arrival in office.

Officials are working on measures to reduce the gap. However, the Department does not yet have a savings plan that covers all the costs that appear to be unavoidable. Hence, I have asked for further urgent work to be done to identify efficiencies and savings. A key aspect of the Budget 2010 settlement was that the performance and efficiency delivery unit (PEDU) was commissioned to support DHSSPS in delivering savings.

I fully support that independent review. It is my expectation that its terms of reference will be agreed shortly and that the work can begin with a view to reporting by September. Timing is vital: the longer that it takes to make changes to deliver savings, the greater the potential impact on services.

McKinsey and Professor Appleby's recent updates provide firm evidence of scope for greater productivity while delivering cash-releasing efficiencies. That is not to say that I would adopt all of the policies or proposals in the McKinsey report. I will not, because some of them are off the wall. However, as others are practical and sensible, we will treat his proposals as an à-la-carte menu.

I am also determined to produce as quickly as possible a viable savings plan for 2011-12 and to set a clear direction for the medium to long term, based on a clear vision of change that focuses primarily on prevention and better public health. Quality, in conjunction with the need to contain costs, should be the first consideration in service change.

The statistics speak for themselves: the productivity of Northern Ireland's hospitals is well

behind that of England's, as demonstrated in, for example, the length of stay of patients. Matching that performance would allow us to treat thousands more people every year without spending a single penny more. Likewise, curbing the growth in prescription drug expenditure, encouraging generic prescribing, removing therapies with little clinical value and encouraging a responsible attitude to medicine management would deliver significant savings.

Some of those proposals can be implemented with little impact on existing service provision. Others may require a radical overall of how and where services are provided to secure the best outcome for patients, because one major factor affecting our relative productivity is the fact that acute sector resources are spread over proportionately more sites than in other parts of the UK, which means that the time and capacity of our specialist staff are used less efficiently. As a region and an Assembly, we have a reality to recognise.

Let us be absolutely clear: I will not shy away from the task that we face. Let me outline some of the key priorities. First and foremost, I want to drive up the quality of services and outcomes. The underlying principle for me and for the vast majority of people working in health and social care is to protect and improve the quality of services. That means that the services must, in the first instance, be safe. They must also be effective and focused on the patient. Patients must be at the heart of everything that we do. We will be measured by how we focus on their needs and how we deal with their pain and distress.

To deliver high-quality services, we must have sound and clearly defined standards for all aspects of care and ensure that services are fit for purpose. We must foster a culture that fully recognises and values the need to learn from our mistakes so that we can continually improve quality. We must be able to rely on a skilled and motivated workforce, have the capacity to measure and monitor the quality of services and develop more integrated functions that focus on people's needs.

Our actions must protect and improve the quality of health and social care services. I want to ensure increased productivity. We have in place performance management arrangements from which we are learning how services can be improved and efficiencies gained. As I said earlier, we can do more to improve productivity, and I want us to endeavour to close the gap with England in that respect.

I want to see greater collaboration with front line professionals. I recognise that the workforce holds the key to providing safe and effective services every day. I put it on record that I place a high value on the individuals who, through their commitment and professionalism, provide essential services, often, as I saw this morning, in less than ideal circumstances. By individuals, I mean everyone involved in the essential support roles, such as the porters, those involved in cleaning, catering and security, those who deliver compassionate care and treatment, and those who pioneer and research new techniques and technologies. All roles are essential to the smooth and effective delivery of care. No less essential are the views of those who shape the policies that determine the services. Those views, from people who know what works and what does not work in the day-to-day environment, will lead to policies that deliver meaningful benefits to people's health.

I am keen for the views, experience and expertise of all staff to be harnessed to best effect in order to shape policy and improve health. I want to ensure that front line staff feel enfranchised and that the resultant policies lead to meaningful change for the benefit of all our citizens. I want to devolve greater decision-making powers to the local level. I mentioned earlier that we need to change the way in which services are provided. It is, therefore, important that those charged with commissioning health and care services feel free to challenge the status quo and ensure that what we do for patients is fit for purpose and offers value for money. More powerful local commissioning is crucial in making that happen, as it will allow decisions to be made to support local communities. In that respect, I want to make sure that the system is clear on the roles and responsibilities of the existing local commissioning groups (LCGs). I also want to be sure that the LCGs are fully representative of local health professionals and local communities, and that they are equipped and supported properly in taking tough decisions on how services will be provided and who is best placed to deliver them.

Patients must never feel that they are being pushed from pillar to post around the different areas of the Health Service in order to receive the care that they deserve. Primary, secondary and community care services need to come together as part of an effective integrated care model so that patients receive the right care and treatment in the right setting from the most appropriate provider. I want to encourage charity and voluntary sector assistance. Public sector health and social care staff are extremely dedicated and provide wonderful care, but they do not have a monopoly on quality care. The voluntary, independent and community sectors already play an important role in delivering high-quality care. The third sector has a strong record in areas such

as mental health, dementia, brain injury and learning disability.

At present, nursing care is almost exclusively provided by the independent sector, with only a few nursing care beds maintained by the statutory sector. If anyone wants to make a case that the situation was better 30 or 40 years ago, when hospitals had long geriatric wards, than it is with today's nursing homes, I am quite happy to take on that argument. I do not want to go back to those days. My Department remains committed to maintaining and developing what has proven to be a successful partnership with the private and third sectors in order to care for some of the most vulnerable people.

I want to promote preventative and early intervention measures. Given the projections for increases in the prevalence of long-term conditions due to lifestyle factors such as alcohol abuse and inappropriate diet, we must act now. Sustained preventative interventions in health promotion are vital in improving population health and reducing the long-term cost to the Health Service. The Wanless and Appleby reports highlight the importance of investing in public health activities and making the public fully aware of their health in order to reduce demand on services. That approach is at the heart of the Investing for Health strategy. There is strong evidence that every pound invested in early intervention can save £7 in the medium to long term. We will not realise the benefit of making that sort of investment now. Perhaps it will be realised in the lifetime of the current Assembly, but it is essential and critical to the future well-being of the Province.

The Family Nurse Partnership programme, which is being tested at a number of sites in the Western Trust area, and the primary-school-based Roots of Empathy programme, which is being tested in the South Eastern Trust Area, are examples of how early intervention works. The estimated savings include the cost of treating childhood conditions such as conduct disorder. They also aim to bring longer-term savings by cutting down on health-risk behaviours such as alcohol misuse.

Where there is a crossover and people are doing work that can have implications on health, I want to work closely with the other Departments. Perhaps information that they garner from their work could be put to good use in the health system. We can operate better together than apart. I will talk to ministerial colleagues to determine how best we can do that.

We also need to limit unnecessary hospital care. Too much work carried out in hospital could be done at primary care level. We need to target good intermediate care, rehabilitation and community support. We need to promote multidisciplinary community teams for chronic conditions such as heart failure and chest disease.

Through managing such long-term conditions in the primary and community sector, we will provide the information, support and early interventions that enable people to manage their conditions better and maintain their independence, and we will reduce avoidable hospital admissions. People given that type of support are more likely to experience better health and well-being, use their medicines effectively, remain at home and have greater confidence. They also have a sense of control and better mental health. The move to more community-based care requires a range of services focused on, for example, early diagnosis and intervention; bolstering multidisciplinary community teams; rehabilitation and good intermediate care services; self-care; education for self-management; and support for carers.

I also want to give patients choice. What really matters to patients is the design and delivery of services that meet their needs and expectations. Patients want to be treated for non-urgent care at a time and place that are convenient for them. Ideally, that is at home or close to home in the local community. I want to enhance the patient experience. Therefore, we need to explore how we can make services more responsive to the everyday lives of patients.

Advance booking is an established future appointment system that enables patients to choose hospital appointments that suit them. The roll-out of the network of new health and care centres will support increased care in local communities. It will also bring together multidisciplinary teams to provide a wider range of integrated services, including an expansion of assessment, diagnostic, treatment and support services.

Crucial to the delivery of improved services in a community setting is the proactive and early identification of people with long-term conditions. That can be done, for example, through GP-practice-based registers, which enable people better to understand their condition and how to manage it. That can enhance their overall well-being and quality of life. A remote telemonitoring project will enable patients to perform tests at home, thereby taking control of their condition and not having it control them. I also look forward to an increased role for the community pharmacy in public health and medicines management, with the emphasis on self-care

and self-empowerment.

It is important to involve and engage patients in any change, but patients do not want change for the sake of it. Choice must deliver better healthcare to meet the needs of individuals and the community as a whole. I am strongly committed to the principle that health and social care should be driven by, and be responsive to, the needs of patients and of their carers. They are at the heart of everything that we do and must be our focus.

I hope that that helps the Committee to understand the direction of travel that I want for the Department of Health, Social Services and Public Safety. I want to keep members informed about that journey and, where appropriate, involve you. It is important, particularly in these challenging times when hard decisions must be taken, that we all pull together for the good and the health of the people of Northern Ireland.

After that, Madam Chairman, I am sure that there are no questions because everything has been covered. However, if there are, I am happy to take them. *[Laughter.]*

Ms Gildernew:

Go raibh maith agat, Minister. Thank you very much for that positive start to this session. You mentioned many issues that we have discussed, including preventative medicine, early intervention and better utilising the community and voluntary sector. I am conscious of time and will try to be as brief as possible.

I will let Jim Wells in in a wee second. First, when will you publish your priorities for action? It would be useful to receive a copy of those as soon as possible. We recognise that this Committee is a very busy one, and we know that you are thinking about introducing legislation. I appreciate that you were limited in what you could say. The mental health legislation will be massive. Years ago, we discussed the adoption Bill in Castle Buildings. May we have an update on the Human Rights Commission's application for a judicial review of the present adoption legislation?

Mr Poots:

I wish to make a number of statements between now and recess, which begins in the first week of July, on priorities for action. We have a short time in which to release a great deal of

information. I came into a Department in which there seemed to be some flux. I intend to get things moving quite rapidly. It is also important that we take the right direction. Some of the information that will be released at an early stage point will be formative. People may want to challenge it, and, if so, we are prepared to listen. However, we need to get the issues out in the open to allow the public to digest and scrutinise them. We will move forward on the back of that.

We talked about the mental health legislation, which will take the form of a huge Bill. However, I am sure that we can give it adequate coverage and are capable of dealing with it.

About three weeks ago, the adoption Bill was put back for two months. The judicial review hearing has been postponed for two months, and we are preparing a case to defend the Department.

The Chairperson:

As mentioned earlier, during purdah, an issue came to light that the previous Committee was unable to scrutinise. Security at Belvoir Park Hospital was breached, and copies of patient files and records were made available for sale on the Internet. I received an e-mail from a woman who was affected. It was extremely distressing for anyone whose loved one had been a patient at Belvoir Park. It is a matter of great concern. We recognise that you were not in your ministerial post at that time, but it is a serious issue, and we would like to know what you have done so far to deal with that breach and how you intend to progress the matter. We also want to know about the policy on patient files, including the time for which they can be retained.

Mr Poots:

That was a matter for the Belfast Trust. However, it is beyond me why, six or seven years since Belvoir Park Hospital was in use, we still hold on to that building and grounds. The Belfast metropolitan area plan identified 23·7 acres that could have been used for the development of homes. The fact that we still own that property demonstrates poor management, particularly given the recent boom and subsequent downturn. One can only imagine what the value of that land in south Belfast would have been in 2007. Instead of sitting on a problem, we should have had money that could have been ploughed back into the health estate, which badly needed it. Obviously, that was not the case. When we sell the land, it will be at a considerably reduced value to that which could have been achieved years earlier.

I deplore the security breaches that took place. The behaviour of individuals who took other people's information, posted it on the Internet and tried to sell it is not acceptable. However, I am also concerned that the breaches took place in the first instance. It is hard to seal off a site of that size. I understand that the Belfast Trust is reviewing the security on the site to determine how best it can manage the situation now. We should never have been in that situation in the first instance. It also draws to our attention the archaic methods of keeping information in an era when everything is going digital. We need to consider the better provision of a digital system to support record-keeping services. It should be a system that enables every doctor and hospital in Northern Ireland to assess the needs of patients quickly. At present, that usually involves someone going to look for files. It is really up to the Belfast Trust, and we have put pressure on it to ensure that security is improved. However, it brings home to us the need to do things better.

The Chairperson:

We know that digital technology is not foolproof either. Are any files still on the site?

Mr Poots:

Yes.

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

My understanding is that all files have now been removed from the site, Minister.

Mr Wells:

The Committee was extremely concerned. Had the incident occurred earlier, there would have been a Star Chamber event for the officials concerned. It was one of the most regrettable incidents that I have encountered. It did not happen on your watch, but I am glad that lessons have been learned.

The other issue is the fact that £186,000 of electricity was burned because nobody remembered to switch off the equipment. Are we absolutely certain that no other defunct or vacant facilities are burning power and wasting public resources? It is important that we learn that lesson.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):

The Department has issued clear guidance to the service and to all trusts about how buildings

should be decommissioned when no longer in use. That sets out clearly all the basic principles of security and how to make the site safe, depending on how it has been used. Obviously, Belvoir had major issues with X-ray equipment. We now have clear procedures, and, as accounting officer, I will need to commission work to establish the effectiveness of trusts' fulfilment of those obligations. Earlier this week, I met the Belfast Trust to discuss that very subject. I wanted to ensure that all the right steps were being taken, that the short-term action that the Minister mentioned has been taken and that we ensure that no similar issues exist elsewhere in the service. We take our responsibility to lead on that seriously, and we will make sure that the guidance is clear and that we have assurance that it is being applied.

Mr Wells:

The previous Committee received evidence from rheumatologists about the problem with anti-TNFs, which are drugs for rheumatoid arthritis. They could be called wonder drugs because, as constituency representatives, we have all seen the marvellous improvement in constituents as a result of their application. However, rheumatologists say that the target waiting list is slipping and that there is a difficulty in getting a first diagnosis and a first recommendation for treatment. However, the Minister mentioned a stitch-in-time situation in which initial treatment can lead to long-term improvements and a reduction in demands further down the line. Can you reassure us that we can get back on to schedule with anti-TNFs?

Mr Poots:

Between 2008 and 2011, the Department allocated £34 million in additional funding for hospital drugs and specialist drugs, which included £11 million for biological anti-TNF drugs for severe inflammatory arthritis. On 31 March 2011, 2,059 patients received biological drugs for arthritis. That is four times higher than the number of people on the same treatment five years ago — 440 in May 2006. The current waiting time before starting treatment for arthritis with biologics is nine months. It is regrettable that patients must wait to start any Health Service treatment. Although that is an improvement on the waiting times of as long as two years previously, it is still not good enough.

Northern Ireland is falling behind the rest of the UK in the number of drugs given the go-ahead under NICE, and I want to look at ways to provide those drugs that will not impact on other Health Service provision. If we cannot identify a better way of doing things and ensuring that anti-TNF drugs and some of the new drugs to deal with cancers are made available, we will sell

people short. Over the next number of weeks, therefore, I will study that issue and bring to the Assembly a proposal on how we might achieve it. I trust that I will get support for that.

The Chairperson:

I concur with that. I have family members who are on those drugs, and they have made an amazing difference to their quality of life.

Mr McCarthy:

I thank the Minister and his colleagues for the presentation. Minister, I was glad to hear you use the words "quality", "protect" and "improve" — those are three vital aspects of care in Northern Ireland. You mentioned your commitment to early intervention, Minister. On 31 May, you stressed the commitment to early years intervention. We fully support that. However, at present, early years intervention services and other organisations are under threat. Home-Start, for example, which has proven its worth over many years, is almost on its knees. Indeed, it is disappearing in some areas because of its lack of resources. What assurance on the immediate future can you, as Minister, give people who support Home-Start and similar organisations?

That question was about the care of young people; my next is about elderly people. On 1 June 2011, at the Chief Nursing Officer's conference, you said that you wished to "avoid unnecessary hospital admissions". We agree with that, but we also hope that you will act to prevent the unnecessary retention of people in hospital through bed blocking. We are aware of the lack of resources in the social care and community packages that enable senior citizens throughout Northern Ireland to get out of hospital. Will the Minister assure the Committee that sufficient community care packages will be in place so that people can leave hospital and receive excellent care in the community, thereby reducing the incidence of bed blocking?

Finally, what progress is the Department making on the single Mental Capacity (Health, Welfare and Finance) Bill?

Mr Poots:

Thank you for that, Kieran.

I will answer your second and third questions, and Catherine will address your first question on Home-Start. Obviously, a decision had been already taken on that issue. I have received

letters from several Members seeking a meeting on Home-Start, and I am happy to facilitate their request.

The Mental Capacity (Health, Welfare and Finance) Bill is a considerable piece of work. I want to bring to the Committee something that has been well thought through and well considered in the first instance. We aim to make that presentation to the Committee in the autumn. It is a Bill to which we must devote a great deal of time. I will have no problem with the Committee's extending the time it takes to go through the Bill in considerable detail in order to achieve the right outcomes. We will depend on the Committee's scrutiny to identify important issues.

As to community care packages, you identified an issue that we must get right. There is no point in starving the social services side of the Department of funding to the extent that it costs the overall Department more money. It is critical that we are able, particularly at the end of the year, to ensure that people can get community care packages put in place to allow them to leave hospital as quickly as possible. Hospital is not where elderly people want to be, and it is not where they should be unless they require medical care. In hospital, they are prone to infection and liable to fall prey to other illnesses. As I said to my officials from an early stage, it is absolutely critical that we get that right. We must ensure that bed blocking is minimised.

Ms Daly:

The responsibility for early years and Home-Start projects transferred from DHSSPS to the Department of Education (DE), which is now responsible for a number of them. However, within DHSSPS, there was some continued funding for projects that had been funded under the former Executive's children's fund. Once that fund ceased to exist, funding continued to be made available within DHSSPS for three years, until the end of 2010-2011. At the start of the Budget 2007 period, the projects funded under that programme were advised that the funding would come to an end in 2011. A year before the end of the Budget period, they were again advised of that position. They were continually advised to seek alternative funding or have in place an exit strategy. That is the overall position.

Mr McCarthy:

I am most disappointed. You are almost washing your hands of a facility that operates right down at grassroots level and caters for youngsters during their earliest development. You are almost

passing the buck, as it were, to another Department.

Ms Daly:

At the start of the previous Budget period, there was a formal agreement to remove that responsibility, which, it was felt, would be better placed with the Department of Education. In the context of the budget constraints facing the Department, the funding for those projects had to be considered in light of the available resources and competing priorities. It was not a declaration that those projects were not important. They were recognised as very important, which is why that funding was continued throughout the previous Budget period. However, that decision had to be taken in the context of the extreme financial position of the Department.

Mr Poots:

The Department of Education is one of the Departments with which I want to discuss issues. It has done excellent work on Sure Start, for example, and put much more funding into the programme than it was originally given. The Department of Education has gone beyond what it was required to do in the first instance, but there have been great results as a consequence. I want to work with DE to identify how we can develop synergies, which can, perhaps, reduce the burden to some extent for both Departments, thereby enabling us to do more elsewhere. I am happy to discuss some of those issues with DE to determine whether we can find a better outcome to the situation than is the case currently.

The Chairperson:

We appreciate the fact that you will work with DE. It is important that those two Departments work closely together. Catherine, my recollection of the transaction during the previous Executive is slightly different, but we will not go there. Plenty of studies prove that every pound spent on early years intervention is worth the equivalent of £17 in later life. Such intervention is vital in getting the population off to a good start.

This is carers' week, and we want to recognise the great work that carers do right across Ireland in looking after their loved ones, whether they are children, parents or aunts. We would like you to take away the message that, with the right care package and the right support at domiciliary care level, we get a service from our carers that we could never pay for if we were to try to put a value on it. Kieran, are you content enough?

Mr McCarthy:

I have to accept what was said, but I appreciate the willingness of the Minister to join the Department of Education in trying to overcome the problem.

Mr McCallister:

That is vital, because many of your areas of work will need support from other Departments. Your Department should not be left to pick up everything on its own and do all of the heavy lifting unsupported by other Departments. As the Chair pointed out, that has huge effects right down the line. The quicker you can become involved with other Departments and create those synergies that you mentioned, the better the outcomes for all of us, particularly for projects such as Home-Start. The Minister will be aware of centres such as ICAN falling apart because of problems between two Departments.

During your presentation, you mentioned getting down to a £150 million shortfall. In the past three years, the Department has taken hundreds of millions of pounds out of the system, and in-year changes have been introduced by the Department of Finance and Personnel. Bearing that in mind, and given that we are so far into the financial year, will that be feasible?

Mr Poots:

By the end of this month, we will have lost the first three months of the financial year. That makes achieving a figure of £150 million much more difficult, because we must do in nine months what we would otherwise have had a year to do. Although the Department has enjoyed a considerable uplift for a period, it has also experienced considerable growth in what is required of it.

I need not rehearse to the Committee that our population is growing older. It is a success that the average age of the population in Northern Ireland is rising. However, that ageing population requires a greater level of care and support. Consequently, the pressures on the health budget are greater.

My starting line, after certain issues have been removed, is £177 million. Greater prescribing of generic drugs can save £30 million, we can take off £13 million through Agenda for Change, and the trusts can take out money through savings that they have put in place already. Therefore, we can achieve a considerable proportion of what is required. We may be required to bid for

support in future monitoring rounds. As little will be surrendered in the June monitoring round, not much will happen this time round. However, I have no doubt that we will make bids in future monitoring rounds for support to see us through.

Aside from the savings that we have identified and will identify, we will open our books and ask DFP to examine them to see whether we are missing anything. We will work with PEDU to identify whether we are making full savings across the board. I want to hear ideas from staff on the ground, from the doctors and the nurses and the people who are involved in the day-to-day running of the hospitals. Virtually every day, I am approached by someone who provides me with suggestions as to how money can be saved. Many of those suggestions involve investment in the first instance to make that saving. Nonetheless, those people also say that, by doing what they propose, they could deliver a considerably better outcome for patients. We will consider all those issues. Some savings will be made in the short term, and others will be in the medium and long term.

You rightly pointed out that we have an extremely challenging target to meet this year. We will do our absolute best to do so, but we will probably bid for more money in future monitoring rounds.

Mr McCallister:

Are you guaranteed any money in monitoring rounds? There is no point counting on £20 million if there is no guarantee of extra money. Do you have any plans to bid in this monitoring round?

Mr Poots:

Not in this monitoring round, because we do not believe there to be much to bid for. We certainly will bid in future monitoring rounds.

Mr Brady:

Thanks for the presentation, Minister. I hope that what I have to say does not sound too parochial, but Daisy Hill Hospital also covers other constituencies and a huge hinterland apart from Newry. It is my understanding that you will visit the hospital soon. There have been a number of issues. Last week, along with Conor Murphy, I met the chief executive of the Southern Trust, and we discussed several issues were discussed. More issues have come to light this week, even as recently as this morning. It is entirely up to you, but this might be an

opportunity to reassure staff of the long-term future of that hospital. There has been a great deal of speculation about specialisation, the relocation of staff and various other similar issues. I know that it falls within the remit of the Southern Trust, but, coming from you, it may give people that wee bit more reassurance.

I reiterate what the Chair said about carers' week. We must not underestimate the value of carers and the financial saving that they bring to the Department. That should always be recognised.

Mr Poots:

We want to reassure people in the Daisy Hill area. You are right to say that its catchment extends beyond the city of Newry. I am sure that the good folk in Kilkeel and down around Slieve Gullion greatly appreciate what goes on in the Daisy Hill Hospital and use it regularly. We want to assure those people that they have access to safe, high-quality services. That objective is foremost in our minds when making our considerations. Discussions are taking place between trust management, trade unions and staff on how services at Daisy Hill Hospital can be improved and developed. I understand that there has been great concern in the local community following a proposal by the trust to combine the existing coronary care and high dependency units in the Daisy Hill Hospital. However, the primary objective of any change is the delivery of quality, safe and efficient care.

I am reassured that those proposals will ensure the future sustainability of both services in the hospital, and they have been supported by the clinicians there. The staff and management have a strong desire to provide the best available healthcare and outcomes for patients. It is in everyone's interest for that hospital to continue to enhance the quality of its services.

Mr Brady:

One issue is that of better communication and information being filtered down to staff. Better communication would have resolved many of the issues.

Mr Poots:

Write to me about any issues, and we will consider them. When I visit Daisy Hill Hospital in the near future, I hope to be able to instil some confidence, even at a local level to the local papers, and so forth, that we still have a strong commitment to it.

Ms Boyle:

Thank you for your briefing, Minister. My question comes in light of the recent incident across the water in the UK. A young guy under the influence of alcohol and drugs presented himself to A&E and spent the night there. There is some disturbing CCTV footage of that incident. Having not been seen, he was found dead the following morning in A&E. What reassurances can the Minister give to the public about the procedures in place in our A&Es? We do not want the same type of incident to happen here. What procedures or protocols are in place for anyone who turns up at A&E under the influence of drugs and alcohol?

I appreciate the pressure that such individuals put on staff in A&E departments. I understand that if blood is taken, for example, such people are seen. Just this morning, however, someone who works in mental health told me that urine samples are not taken. If those were to be taken as well as blood, it would lessen the burden on the staff. Results would come back more quickly, and staff would know whether there were narcotics as well as alcohol in a person's system.

Mr Poots:

I will ask Michael to cover some of that, but I will respond initially. Working on the very front line, A&E staff are under immense pressure and face much verbal and physical abuse. The pressure that they may be under because of the number of people whom they have to attend can be absolutely phenomenal, and much of that stems from alcohol abuse.

Two and a half years ago, I visited A&E in the Royal as a carer, and I waited until 3.30 am to get a bed for a vulnerable person. In the course of the evening, I observed quite a bit. In the early hours, as things settled down a little, I had a conversation with the sister. I said that a high proportion of their work appeared to be led by alcohol abuse and that many of those seeking treatment had been drinking heavily. She told me that well over half of the people there were be under the influence of drink. When I pointed out that it was the middle of the week, she told me that it did not matter. She said that it was like that every night of the week because of the cheap alcohol sold by supermarkets. I want the public to take in the fact that staff are under immense pressure, and people requiring treatment do not receive it as quickly as they should because supermarkets sell alcohol at below its value. As a consequence, hospitals are being clogged up, and other patients are being denied timely treatment. Ultimately, many more people will report to hospitals with severe liver malfunction, a condition that is developing earlier and earlier. That

said, those who turn up at hospital under the influence of drink deserve to be treated, irrespective of whether they have had too much to drink. I will ask Michael to respond to this particular case and how we would deal with that.

Dr Michael McBride (Department of Health, Social Services and Public Safety):
I am not familiar with all the details of the case, but I am happy to find out about it and come back to you with further details. I reiterate the Minister's point that, at peak times, eight out of 10 attendances at A&E departments are alcohol related. As the Minister also said, somewhere in the region of 3,000 admissions and 300 deaths each year are a direct result of alcohol, and those figures are increasing. Northern Ireland has an unhealthy relationship with alcohol — that is a fact.

In 2010, the Department commissioned work that showed that the cost of alcohol-related problems to the Northern Ireland economy was about £600 million a year. Of that, the cost to the Health Service was somewhere in the region of £122 million, and the cost to the criminal justice system, including policing, was approximately £300 million. However, those figures do not take into account the human cost to individuals, children and communities.

We have a significant problem, which is why the Minister referred to the need to curb irresponsible promotions of drink sales. During the previous mandate, the Department for Social Development (DSD) brought through legislation on that issue, and the Minister for Social Development will, in due course, consider regulations. There is also an ongoing consultation between DHSSPS and DSD on minimum unit pricing for alcohol. That consultation is current, and it is important that all those with an interest in the consequences of alcohol in our society respond to it before the end of June.

Recently, we consulted on 'New Strategic Direction,' which is the policy document for the departmental approach to drugs and alcohol. That approach was reflected by working in partnership with several Departments, including the Department of Justice (DOJ) and DSD, to name but two. In that document, subject to ministerial consideration and publication, we will specifically consider adopting a four-tier approach to services, including wider public education on the harmful effects of alcohol, which will involve support for schools and the raising of awareness. That approach will also be used in the provision of services for those addicted to drugs and alcohol, which is an area that requires further consideration and development.

On the specifics of the case in question, there are, as the Minister pointed out, complex issues with any individual who presents to an A&E department. We need to ensure that individuals are protected from harming themselves, and we must not infringe on their human rights. We must also ensure that staff are protected in what are often highly challenging environments. It is important that anyone who presents to any health and social care facility, whether an A&E department or a GP's practice, is afforded the appropriate support and care that they require at that time. I know of no similar incidents in Northern Ireland. I am happy to examine the specific details of the case, although I am not familiar with it.

Ms Boyle:

It broke on the news only this morning.

Dr McBride:

I am sorry that I do not know the exact details. Our nurses, doctors and other A&E staff are strongly committed, and we have close working relationships with the PSNI in local areas. We also have a range of alcohol liaison nurses in trusts throughout Northern Ireland, and we are keen to extend their use in brief interventions. Many of those who attend A&E departments with alcohol-related problems are repeat attendees, and it is important that we reach out with brief interventions to address their harmful drinking behaviour. There is evidence that those programmes can reduce problem drinking by somewhere in the region of 40-fold. Therefore, we need to consider taking a much more proactive approach to identifying and addressing problem drinkers in society, particularly those who come into contact with health and social care.

Ms P Bradley:

I thank the Minister. I am encouraged by your priorities for the time ahead. The words that rang out over and again were patient choice and patient-focused services, which is as it should be.

Healthcare workers have been under pressure for years, no matter what their discipline, and they have gone over and above their job descriptions. However, in the past year or two, the goodwill of staff has slowly eroded. Therefore, I am glad that you want to make staff feel enfranchised again, because they certainly feel disenfranchised at the moment. They feel that they are not part of the decision- making process, so your talking to the people who provide front line services and making them feel part of that process is a positive way to achieve increased

productivity.

You talked about the increased lengths of stay in hospital. I assume that that is not all due to bed blocking. I know from working in the Health Service that the number of people waiting for a nursing home place or a care package is much reduced compared with years ago. What are the other reasons for the length of stay in Northern Ireland hospitals being higher than in other regions?

Secondly, Southern Cross Healthcare, which has 25 facilities in Northern Ireland, has just announced 3,000 job cuts. What impact will those cuts have on staff and service users here?

Mr Poots:

On the subject of bed blocking, the release of people from hospital must always be a clinician's decision. It can never be driven by financial considerations. It has to be a clinical decision based on the facts that patients have received the necessary treatment and releasing them will not impinge on their recovery. However, Northern Ireland patients spend, on average, 1·2 more days in hospital — 20% longer — than those in the rest of the UK. Perhaps Michael will pick up on the reasons for that.

Dr McBride:

An important benchmarking exercise was carried out across the United Kingdom to look into why Northern Ireland has areas with significantly longer lengths of stay. I will put that in context: we have had reducing lengths of stay compared with other parts of the United Kingdom. I hate to use the word, but we need to analyse a number of bits of "process" in health and social care, including the decision to admit a patient to hospital. Even before an individual gets to the front door of A&E, we must consider whether it is the right place for him or her to present.

As the Minister said, although, on average, we are living longer, we are not necessarily living healthier lives. Indeed, we are developing more long-term conditions. At its inception, the Health Service was designed to deal with episodic care and once in a lifetime, potentially life-threatening illnesses. It was not set up to provide what is increasingly happening in an ageing population: long-term condition management, which the Minister mentioned in his presentation. That requires a much greater focus on primary community services, supplemented by the voluntary sector to keep people out of hospital; much more patient education on self-care; and

much more effective use of drugs and treatment.

When people arrive at A&E, decision-makers must determine the appropriateness of their admission. We have been benchmarking best practice in the rest of the UK in order to estimate patient discharge times from the minute they enter a hospital ward. Consequently, as soon as a patient occupies a hospital bed, as well as getting on with treating the underlying condition, we begin to plan for his or her effective discharge, which, as the Minister said, requires input from key decision-makers, such as senior consultant medical staff, nursing staff and the whole team of physiotherapists, occupational health physicians and pharmacists. By taking that approach in a number of hospitals — work in the Northern Trust is ongoing, and work in the Southern Trust has been completed — we have been able to reduce the length of stay. Those are just two examples. That approach must be the norm, rather than the exception.

One of the greatest improvements has been the use of specialist nurses as discharge co-ordinators to co-ordinate the arrangements for individual patients being released from hospital. As the Minister said, patient needs are becoming much more complex. A team approach is, therefore, needed to ensure that, from the moment a patient arrives in a hospital bed, we co-ordinate and set up the package of care and use all the relevant expertise to plan for a safe and effective discharge. We must do more of that in a much more co-ordinated way.

Mr Poots:

Refresh our memories on the second part of your question.

Ms P Bradley:

It was about the impact of job losses in Southern Cross facilities.

Mr Poots:

I discussed that with the Regulation and Quality Improvement Authority (RQIA) earlier today. Several of the Southern Cross facilities probably do not have enough residents at the moment, and those facilities may, therefore, present more of a challenge. However, we hope that a package will be brought forward to ensure that Southern Cross facilities transfer to another care home provider. KPMG is leading on that issue, and we are monitoring it closely. At the moment, we believe that the outcome can be positive; it does not have to be negative. However, some of the homes may not be as easily sellable as others because they are a little run down.

The Chairperson:

Four members still wish to come in, so I ask that all questions and answers be a wee bit more succinct, because I want to make sure that everyone gets a chance to ask their question. You have been very patient, Sam.

Mr Gardiner:

I have, and I will be very brief, too, seeing that you asked.

Thank you very much, Minister, and congratulations on your appointment. I welcome you here today. You are like a breath of fresh air.

I was disappointed — in fact, my heart sank, and my enthusiasm for the Health Service plummeted — when I heard your opening remarks on what is going on in the Health Service, why the service is not being delivered and how we are not getting value for money. I am glad that you brought that to the Floor of the House. However, I must point a finger at Dr McCormick and Dr McBride. You people cannot run away from this. You have a great responsibility for which you are well paid. However, in my opinion, you have failed. Now that I have said that, I hope that there will be improvements from now on.

Minister, I know that you will be honest, upfront and frank with us. When will work on the Banbridge health centre commence?

Mr Poots:

The business case for Banbridge health centre is being considered. We have set aside some money for that, but we do not have it all. I think that the total cost will be £15 million, and we have set aside £8 million in this financial year. It is intended that work will start in this financial year, but that is reliant on the business case. However, I should say that —

Mr Gardiner:

Sorry, did you say that the total cost is £15 million?

Mr Poots:

Yes. I do not have the figures in front of me, but, from my recollection of the capital estate, the

total cost is £15 million, and we have set aside £8 million for 2010. Chair, £851 million will not meet our infrastructure needs over the next four years, but that is the amount set aside.

In the next week, I will meet the Strategic Investment Board (SIB) to discuss all of that. The primary and community care infrastructure (PCCI) document, which was produced in 2006, identified a roll-out of such primary care facilities. I am keen to progress the primary care facility in Portadown, which, I believe, is an exemplar of what should exist across the Province. At present, several such facilities are off the schedule for the current spending round, including one in Lisnaskea, which the Chairman might be interested in seeing proceed. I will ask SIB to determine how we can reconfigure resources to ensure that we maximise delivery and output on the capital side. That may involve talking to the Finance Minister about our giving back capital moneys in return for more current funding.

Let us give serious consideration to how we can meet the needs of an ageing estate. This morning, I visited the Ulster Hospital in Dundonald. I was taken to the new critical care unit first and then to another unit, and the difference between the two was night and day. Our desire is to emulate the new unit, but we cannot achieve that with £851 million. Therefore, we will have conversations to determine whether we can deliver more, and I will be happy to report back to the Committee and Assembly if I am in a position to do so.

Mr Gardiner:

I just want action now.

The Chairperson:

We will have to give you a photo of him cutting the ribbon.

Mr Gardiner:

I do not care about the photograph, as long the work gets done on site.

Mr Durkan:

I welcome you and thank you for your presentation. I was interested to hear your ideas and delighted that I share many of them. I am glad to hear about your commitment to cross-departmental working. That will have a real, positive effect on many people in many different areas, none more so than in special needs provision, which was the subject of a debate last week

in the Assembly.

Last week, Co-operation and Working Together (CAWT), which is a partnership working in the North and in the Republic, gave a presentation to the Committee. Do you envisage any areas in which further exploration of cross-border co-operation could achieve savings and improve service delivery for people living in border areas? You have already demonstrated willingness, where it makes sense, to co-operate and collaborate, and you referred to the radiotherapy centre. Again, I congratulate you for your decision on that. During your tenure as Minister, do you envisage any areas in which further co-operation could improve services?

Mr Poots:

For me, the issue is health, not politics. To me, it is logical to achieve an outcome that enhances people's opportunities for a good Health Service, often at a reduced or shared cost. We cannot move away from logic when it comes to dealing with those issues. In certain instances, such as when developing the Erne Hospital, there is the potential to provide services that would not be supported by a consultancy team if they catered for people only from Northern Ireland.

Opportunities also exist in Daisy Hill Hospital, and consideration is being given to where services can be provided. That will provide additional income to the Northern Ireland Health Service stream, which will better enable us to serve our constituents. I will consider issues purely from the perspective of how we can provide better healthcare, and I am happy to engage with Minister Reilly on a one-to-one basis. I am also happy for my Chief Medical Officer to engage with his counterpart to identify how good solutions can be arrived at. Anything that we do will be done on practical health grounds and for no other reason. Nothing will be excluded, which will be beneficial to us from a practical health perspective.

Mr Durkan:

Thank you, Minister. I am delighted to hear that. You said that it was important to make the best use of every single penny, and the Dublin Government will be keen to make the best use of every single cent. Collaboration and co-operation are crucial to that.

The Chairperson:

I appreciate that we have gone slightly over the hour already, but two members wish to speak, and I want to allow everybody an opportunity. You look very relaxed, Minister. Are you in any

rush?

Mr Poots:

Somebody outside might be, but I am not.

Mr Dunne:

Welcome, Minister. Congratulations on your appointment to a difficult and challenging role. We have every confidence that you will do a good job. We welcome the objectives that you laid out. Your fresh approach is welcome, and we look forward to progress. How do you plan to improve the provision of quality front line services against the perceived over-provision of management structures in the Health Service?

Mr Poots:

I note the word "perceived". There is a perception that management is still top-heavy, but it accounts for only 3·2% of spend in the health budget. Therefore, although there is a perception, and it may be more than a perception, that there are still too many people with white collars in hospitals, reducing the size of management is not the magic bullet in having enough finance to resolve the outstanding issues. We will have to consider other areas. I have already asked officials to look again at management and to drive out any further inefficiencies and duplication that exist therein.

I have also asked officials to review the amount of paperwork that medical staff must complete. This morning, the chief nurse at the Ulster Hospital said that about 75% of their paperwork was absolutely necessary. However, she also said that if there were investment in ICT, much of that could take place at the bedside, as opposed to back at the nurses' station. That would enable nurses to do their job better and ensure that the qualitative written information required was obtained and passed on to nurses on the next shift.

Other areas that must be reviewed include the Ambulance Service. Quite a number of ambulance personnel, particularly in the west of the Province, are now trained to treat thromboembolism in people who have suffered a heart attack. That will deliver far better outcomes. It is good that that treatment is readily available to people in the west. It was right to provide it to people there first because they are further from hospitals, but it would be good to roll it out throughout Northern Ireland.

A man from the Downpatrick area had a stroke and was brought immediately to the Ulster Hospital at Dundonald, as opposed to his local hospital. The outcome was that the gentleman walked out of hospital the following week rather than leaving his local hospital months later in a wheelchair. That is a better outcome. We have to reach decisions that will lead to such improved outcomes. I am absolutely certain that the man was happier walking out of hospital this week than he would have been staying in his local hospital. Sometimes, we have to take difficult decisions. However, if they deliver better outcomes for patients, that is what we will do. Much of what we do is, therefore, not about saving money; it is about delivering better outcomes for patients. Occasionally, when those aims coincide, we will be able to do both, which is a win-win situation for everyone. That is the sort of initiative that we are considering. I could go on all day, but the Chairperson told me to be brief.

Mr Dunne:

Thank you.

Mrs Lewis:

I also congratulate the Minister on his appointment. I thank him for his time, and, indeed, for going over his time. I will not keep you long, Minister. Your fresh approach is welcome, and I am sure that you will do well in your post.

Are plans for the improvement scheme, the £15 million proposed extension, at Antrim Area Hospital to go ahead? If so, when do you expect that to happen?

Mr Poots:

During yesterday's debate, I outlined several proposals for Antrim Area Hospital. Temporary medical beds will be put in place by November 2011, and 24 further permanent medical beds will, I believe, be put in place in 2012. Andrew is just looking through the relevant papers. We also intend to build a new accident and emergency unit for Antrim Area Hospital. We do not intend to upgrade the existing one, but to build a new facility at the cost of some £13 million. That will accommodate 90,000 attendances per annum.

Funnily enough, at an event in Antrim Area Hospital, I bumped into a consultant. He said that the problem was that even though they have driven down waiting times from over 12 hours, more

than 200 people still waited too long, which is not good enough. Bed turnaround is much quicker, and the consultant said that the domestic staff had played a key role in that. They clean the rooms immediately after a patient leaves so that another patient can be seen very quickly. It demonstrates that care involves everyone in the hospital, not just the consultants or the nursing team. It is a question of what the entire staff offer, and everyone has a role to play. I appreciate and value the work that every single person does when treating people in our hospitals. We hope to move ahead with the proposal next year, and significant improvements will be made to Antrim Area Hospital as a result.

The Chairperson:
Minister, it has been a useful session, and I am glad that everyone got to ask a question. There will be a considerable amount of engagement between the Committee and you and the Department.

Before you leave, I want to take your mind on a couple of things. This morning, there was some conversation about Dr Brian Dunn's comments on there being too many hospitals, and so on. We have experienced some extremely difficult times in the past, and I accept that difficult decisions will probably have to be made. However, there is a good geographical spread of members on the Committee, and I make the case that morality must be a consideration when ensuring that many people do not have to travel to Belfast or Derry for acute services. That would be untenable, and we want that morality to be factored in at every stage.

In a previous mandate, we had a good discussion on the rural White Paper, and I ask that it be factored into your decisions across the board. We look forward to welcoming you to the new hospital in Enniskillen, which will be the exemplar for acute services and how to deliver for an entire rural hinterland.

Earlier in the meeting, we discussed the three-year rule, which came to light on account of the situation across the water. The European Commission accepted the complaint about the three-year rule on pharmacy services. The rule barred people from other EU member states from running a pharmacy in Britain if they had not been qualified for more than three years.

We have been told that removing the three-year rule will not apply here because of a drafting error in the Health Act 2006. Will the rule still apply here even though it no longer applies in

Britain? Does the three-year rule apply in other EU member states, or are we in the unique position of its still applying here? Do you intend to correct the drafting error? What is your view on it? I envisage a situation in which, after the issue has been resolved in England, Scotland and Wales, someone will come to the Health Committee to find out why the rule has not been removed here.

Mr Poots:

On the issue of acute services, the west of the Province cannot be abandoned. Altnagelvin Area Hospital does not cover the west of the Province; it covers the north-west of the Province. Craigavon Area Hospital does not cover the west of the Province; it covers the south of the Province. That leads us to the conclusion that the west of the Province needs provision, and we are building a brand new hospital in that area at a cost of about £300 million. That is an indication of our strong commitment to providing services, which go beyond minor services, in the west of the Province.

Nonetheless, at the same time as providing a good hospital with a range of services in the west of the Province, we need to upgrade significantly the primary care facilities across Northern Ireland, including those in the west. We need to improve the ability of the Ambulance Service to respond, particularly to the catastrophic incidents of heart attacks and strokes.

You quite rightly referred to the three-year rule. The 2006 Act read "GB" as opposed to "UK", so the rule never applied in Northern Ireland. However, the amendment under the Medicines Act 1968 requires the joint signatures of the Secretary of State for Health and the Northern Ireland Health Minister. I sent the Committee a letter on that issue on 1 June. I do not know whether you have received it yet.

The Chairperson:

I have not received it. I know that you are a co-signatory to the amendment. I wonder whether the three-year rule, whereby some European pharmacists will not be allowed to run pharmacies, will still apply here but be removed in England, Scotland and Wales.

Mr Poots:

That is the situation as it stands.

The Chairperson:

Do you have any thoughts on changing it? If it comes to our attention, we will come back to you.

Mr Poots:

To be honest, it is not the issue putting most pressure on me at the moment. If I find that we are outside of EU rules, and so forth, we will have to respond.

The Chairperson:

OK. If that is it, I thank the Minister, Catherine, Andrew and Michael for coming along and being so generous with their time. We look forward to working with you again. We welcome your constructive approach thus far and look forward to continuing in that vein. Go raibh míle maith agat.