Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Programme for Government

14 December 2011

NORTHERN IRELAND ASSEMBLY

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COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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

Witnesses:
Mr Fergal Bradley)
Dr Michael McBride) Department of Health, Social Services and Public Safety
Dr Andrew McCormick)
Ms Julie Thompson)

The Chairperson:

I welcome the team: Andrew again, Dr Michael McBride, Fergal Bradley and Julie Thompson. There are a few things in the 'Health Matters' magazine that I am very glad to

see, particularly the thoughts on breastfeeding. I am very pleased to see that in there. It is a good wee magazine and is very useful for members of the Health Committee. You are smiling, Andrew. He is thinking, "She never says anything nice to me." Again, you are all very welcome. Who is going to do the presentation?

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

I will just say a few words. Given the Committee's busy agenda, I will not dwell unduly in my introductory comments. Thanks for the opportunity to cover this very important issue. In the context of the previous evidence session, we will step up a level to look at the Executive's priorities and the development of, and agreement on, the Programme for Government (PFG). I obviously appreciate your willingness to defer the discussion on the investment strategy. Thanks for that, Michelle; it is appreciated.

The draft Programme for Government was presented on 17 November. It is out for consultation until 22 February, and the Office of the First Minister and deputy First Minister (OFMDFM) is taking the lead on it. There are five high-level priorities, which are set out in the briefing paper. The Executive made a total of 76 commitments. We, as the Department

of Health, Social Services and Public Safety (DHSSPS), will lead on five of them but will obviously contribute to others. That links to what we were saying in the last session about the importance of joined-up government and of Departments working together on cross-cutting priorities. That is very much the approach that was taken to the development of the

Programme for Government and the work led by OFMDFM.

We have tried to provide information on your questions about the rationale for the selection of the commitments. Three of the five, which are numbered 1, 3 and 4 in the briefing paper, were selected to focus on public health. That again emphasises, as the Minister said yesterday, the fact that public health issues are of interest to all Departments. They need to receive significant contributions from all Departments, and Michael's support for the Minister in the ministerial group on public health is integral to that work as well, as some of the bilateral and multilateral work that we are increasingly getting involved in as this unfolds. The Executive clearly gave a signal that there is a centrality and importance to the public health agenda. I am sure that we can come to that in discussion. The emphasis is on the need to proceed with better early intervention and prevention, to increase funding incrementally over the three years to reach an additional £10 million per year recurrently by

2014-15.

Commitment 2 in the briefing paper, on long-term conditions is, again, absolutely at the heart of our own strategic approach, as was recognised at Executive level, and is closely aligned with public health. The fifth commitment covers a range of areas where we are seeking to improve the quality of care and the outcomes for patients and clients. Some points that came up earlier are relevant to the milestones set out under that commitment.

In addition to the material in the top-level PFG itself, there is also the development of further departmental strategies, frameworks and guidance. We also recognise that there are a range of commitments in the Programme for Government led by other Departments that are very relevant to us and our arm's-length bodies.

There will be clear systems and processes to monitor the progress of our commitments in the PFG and through the normal accountability and business planning processes that we have in place. Also, the draft PFG says that:

"Clearly defined lines of accountability, supported by effective monitoring and regular (quarterly) reporting regimes, are a prerequisite of this Programme for Government. The Executive will agree on the approach to delivery and the mechanisms to support this, and detailed guidance will be produced."

That is being led by OFMDFM and is a clear message that Ministers collectively expect Departments and arm's-length bodies to play their full part in delivering on those commitments and milestones. That is being worked out, and we expect further clarity on that from the centre before long.

A few brief points on lessons learned from the 2008-2011 PFG. The significant reduction in the number of items gives it a much more strategic focus. If there are too many priorities, that undermines the process. That is a lesson learned and applied. Some of the targets and priorities from the previous PFG cannot be fully dealt with as yet because they were not achievable within the time frame. Some of the indicators had target dates after 2011 or there were issues about the availability of data. Those are things that we have all tried to avoid in putting together the new work.

The Chairperson:

Andrew, I am curious. You said that there were possibly too many targets in the previous Programme for Government, but how many were met? How many were green, amber and red? If there were too many targets, we seem to have gone from one extreme to the other because I think there are too few targets in this programme. For example, there are too few markers to enable us to scrutinise fully the outcomes. How do we know that the things that the Department is doing are the right things to do if we cannot measure those outcomes? There is quite a focus on tackling obesity; there is a key commitment to invest £7·2 million in programmes to tackle obesity. However, the same commitment is not there around smoking cessation, for example. There are big gaps in the targets and the measurable outcomes and in the ability for us to work together to see if we are doing a good job.

Dr McCormick:

It is important; that is why I said that we will be pursuing a fully balanced set of targets, indicators and strategies across the full range of our responsibilities. That will be done within our departmental planning processes and in the direction that we give to the arm's-length bodies in their different ways. The commissioning plan direction will need to be

comprehensive, and the work of the Public Health Agency, which I am sure Michael will be happy to talk further about, will be more broadly based. The Executive took a decision to be very selective and to reduce significantly the number of commitments to be made in this round. That is their prerogative. Obviously, we had input in advising on that, as did the Minister. We have been given a remit as to what was selected at Executive level and at OFMDFM level for the highest-level document, but it is definitely supported by a department-level plan for the service, which is important.

Last time around, there were a total of 60 relevant indicators: 21 achieved a green ranking at the end of that period; 22 were red and there were 8 each in amber and green/amber. A number were not fully assessed.

Mr Fergal Bradley (Department of Health, Social Services and Public Safety):

There were 15 areas or indicators for which the delivery date was after 2011 or for which the monitoring information is not yet available because it is taken from surveys that are conducted every two or three years. We will not know the full position in terms of the old Programme for Government until next year, but we are committed, and, as is outlined in the

draft Programme for Government, we will continue to monitor all those indicators throughout the years ahead so that we find out what the final position is.

The Chairperson:

When do we expect to see that annex or appendix?

Mr F Bradley:

For the final set of indicators? We will be able to report on most of them before the end of 2012.

The Chairperson:

Some of the targets in the departmental appendix may be rolling targets and we may not have the information, but we would have thought that, as the mandate has been in place since May, even if the Executive decided that they would not include those kinds of figures, the information is still sitting there; it is ready for us to see what the Department wishes to achieve.

Dr McCormick:

There are two levels of answer to that. Yes, where information specific to the old targets is available and has not already been provided, it can be provided. The forward look could include a consideration of what is going on in the commissioning plan. The Minister gave a clear steer in the development of the commissioning plan direction for 2011-12. That has turned into the boards' commissioning plan, which is now approved for 2011-12. We are now moving into the next cycle and we are working on the commissioning plan direction for 2012-13, which will include a fully balanced package of the Minister's priorities, targets and standards for health and social care. That will support and provide the further detail and background that would make it more balanced.

The Chairperson:

The difficulty is that the PFG is out to public consultation but the commissioning plan is not. It seems as though we are being asked to take an awful lot on trust. There will not be the same scrutiny of the commissioning plan. There are obviously concerns around the table, which you have heard for the past hour and a half, and in the public domain. There are people

who want to feed in, but they are feeding in on aspirations and — I do not want to say "woolly ideas", but I cannot think of a phrase that says it more politely. If we do not get the specifics now, when will we get them? That is what we will use to measure how we are getting on. Other members may want to pick up on that point.

Mr Wells:

As an aside, I really like the layout of the Chief Medical Officer's report. Normally they are quite turgid, dry documents, but this one is very readable and extremely interesting. Maybe that is a lesson for other Departments: when producing reports, make them as readable as possible.

I was disappointed to find that only seven of the 76 commitments in the Programme for Government are health-related, given that the Health Department spends 40% of the Budget. I just want to tease out whether you put an awful lot more commitments in that were then rejected. Are you allowed to comment on that? Was there an attempt to make certain that a least a third of them were health-related, or were you told that you were only going to get five, so you concentrated on what you thought were the main areas?

Dr McCormick:

As part of the process, the starting point rule of thumb was a broad number per Department. I am sure that if the Committee feels that there is room for a different balance, Ministers might want to consider that. We worked through a process of engagement with OFMDFM officials as soon as the new mandate began. However, the final decision about the selection of commitments and indicators was a matter for the centre. We put forward a range of options that it considered and drew conclusions on. As has been said, this is a draft Programme for Government, so if there are views and comments on how it can be improved, I am sure that everyone, from us to OFMDFM, will be more than willing to reflect on that.

Mr Wells:

So a Department like Culture, Arts and Leisure, which could fit into the broom cupboard of Health in terms of budgets, gets five commitments, and Health, which spends between £4·3 billion and £4·5 billion, only gets five commitments. That strikes me as inequitable.

Dr McCormick:

That is a comment that I am sure people will be aware of.

Mr Wells:

I think that the Committee would like to see greater emphasis on Health, because it is by far and away the biggest spender. When I opened the document, I felt that the Health Department, in my opinion, did not get the mention that it deserved, given its size and importance to the community.

Mr F Bradley:

I think that it is worth noting that the previous Programme for Government had 334 targets. So, the Executive's general downsizing of the number of commitments affects all of the Departments. Working within that much reduced number of potential commitments, therefore, reduces the scope. However, this year, the centre has tried to balance the Programme for Government in order to reflect the totality of what the Departments are doing.

Again, as the permanent secretary said — this is in the paper — there is a selection of things in the Programme for Government. In this case, it focuses on public health, but that is not the totality of the commitments or the Department's priorities. There are a wide range of strategies out there. When the Minister appeared before the Committee, he said that he expected to be in a position to issue the commissioning plan direction by January 2012. That will give a much broader steer on a wider range of commitments in other areas. It is about taking the totality of the package. It is also about the Executive's decision about how they wanted to develop the Programme for Government and, as I say, to make sure that it fully reflected the widest range of Departments.

Dr McCormick:

Budget size is not everything.

The Chairperson:

The Department previously had a good chunk of the priorities. The point is that the Health Department has such a big budget and so many targets that affect every other area. It had 60 out of 300-odd, and now it has less than 10% in this Programme for Government. If that is the

decision of the Executive, what was prepared for the Programme for Government that did not make it into the document? We still think that that is sitting somewhere, and we would like to get a look at it.

Dr McCormick:

We will be happy to come back to you on that and see what the Minister wants to put forward on that basis. A number of other proposals were under consideration, but it is his prerogative as to which of those to highlight. I assure you that everything that was considered will be reflected in the further work on the commissioning plan direction. That is the next level down. We will certainly be able to share that with you at an early stage. The firm intent is to have that in play and being discussed at a much earlier stage. Obviously, the process for 2011-12 was uniquely affected by the delay in the Budget process and the election. We are now at a stage at which we can and should be able to work with you at a much earlier stage on the 2012-13 commissioning plan and so on.

Mr Wells:

It would be nice to see what is lying on the cutting room floor.

Dr McCormick:

The director's cut.

Dr Michael McBride (Department of Health, Social Services and Public Safety):

I very much welcome the commitment in the Programme for Government for the public health agenda. As you said earlier, my annual report shows that there are a very significant range of public health challenges. Clearly, it would not be possible to reflect all those in the Programme for Government. There is an old adage that if everything is a priority, nothing is a priority. It is about ensuring that we create the circumstances in which we have a way of working across the whole of government to address those issues and that that encourages Departments, whether that is on a bilateral basis or with more than two Departments involved in taking forward a range of other strategies.

We have a significant body of new strategies coming out for consultation in the new year, including a refresh of the Protect Life strategy, the challenges we face around suicide and the

mental health promotion strategy, which is subject to consideration by the Minister and Executive approval. To reiterate the point, the tobacco control strategy, which, again, is subject to Executive approval, will be out for public consultation. I do not wish the Committee to take the view that those issues are of lesser importance or that the Department will not be driving those through, working in partnership with other Departments, with any less vigour because they are not included in the Programme for Government. The Programme for Government clearly states that the health of the population of Northern Ireland and action that we take to improve the life expectancy of the population and reduce health inequalities is at its centre. We will be taking the long-term view and the approach of early intervention and prevention as a core activity across the entirety of government. That sends a very strong and powerful message.

Mr Wells:

On priority 2, the second key commitment is investing £7·2 million in programmes to tackle obesity. The desperately difficult issue we have with obesity seems to be very much flavour of the month. How much have you actually invested in that field in the previous three years? I have read your report, and it concentrates highly on lifestyle choices and issues like alcohol

and smoking. Why have you specifically targeted obesity rather than those other two factors, which are also hugely important when it comes to people presenting themselves for treatment?

Dr McBride:

As I sought to highlight in my annual report, obesity is one of the most significant public health challenges that we face. If we look at its impact at a global level, we can see that it ranks seventh or eighth as the most important contributing cause to premature death and other associated diseases. We know that obesity is linked to some of the biggest killers in our society: heart disease, stroke, diabetes and certain types of cancers. We have demonstrated over the past 30 years or so that, because of the change in how we live and work, what we eat and levels of physical activity, we have created what is often referred to as an obesogenic environment. In the latest survey in Northern Ireland, somewhere in the region of 59% of adults were overweight or obese and 8% of children under the age of 15 were obese. Those are quite staggering statistics. Obviously, there are issues that we need to fundamentally address. We have made much progress in relation to this entire area. Until the publication of our previous strategy, 'Fit Futures', which looked at addressing the challenge of childhood

obesity, we had year-on-year increases in obesity levels in Northern Ireland. As reflected in the most recent survey, we have achieved a levelling out of that increase from 2007 onwards. In the last survey, we did not see the same increases in levels of childhood and adult obesity.

We now need to make a concerted effort to reduce obesity levels in society and the conditions that result from obesity. We have had some key successes in that area. It is important that we redouble our efforts. Indeed, as I picked up on from some of the discussion earlier, we need to skew an increasing part of our health expenditure to the prevention side. This demonstrates the commitment of the Executive and the Health Department to addressing the challenges of obesity in society.

Mr Wells:

But is this is a significant increase? The PFG does not tell us what we were spending before the £7·2 million. Is that significantly higher, or is it just a continuation of the trend?

Dr McBride:

From 2007 onwards, we were spending in the region of £800,000 per annum on the implementation of the 'Fit Futures' strategy, which was addressing the problem of childhood obesity.

Mr Wells:

So, it is a very significant increase.

Dr McBride:

We were spending £500,000 on work relating to the target to increase physical activity levels. We have to bear in mind that, set against that, only 38% of us actually do the recommended amount of physical activity per week. Again, it is due to the environment in which we work and live. Expenditure in respect of food and nutrition and ensuring that we get the right messages across about what people should be eating was in the region of £300,000.

That is the totality of expenditure over the last period relating to ongoing work such as 'Fit

Futures' and work on food and nutrition. The level of expenditure that is proposed in the draft Programme for Government, which is out for consultation, is welcome. It is important that we make use of that expenditure to address the very significant problem that we face.

The Chairperson:

That was very interesting, Michael. There are graphs and things in the 0-5 book that you get when a child is born. However, as a parent, it is hard to know. I am just thinking aloud. It is a right while since my GP said, "Michelle, you are obese." Instead, I was told, "You are not in a healthy weight bracket."

Mr Wells:

He was a very brave man.

The Chairperson:

He was.

Dr McBride:

I could not possibly comment on that, Chair.

Mr McCallister:

Is he out of hospital?

The Chairperson:

I would trust him with my life, and I would be quite happy with whatever he had to say.

Kieran, John and I were at a centre of clinical excellence discussion in Crawfordsburn a couple of weeks ago. Eddie Rooney from the Public Health Agency (PHA) was there and I said that the wee booklet that is sent home from school that sets out the 60 minutes a day of exercise for children is a great initiative and very welcome. However, following on from the 0-5 book, there may be scope for parents to get a book with a graph at the back for height and weight so that we, as parents, can monitor children. It does not have to be the Department of Health. We, as parents, could monitor whether our child is in the unhealthy bracket and then

modify behaviour at home.

I think I have said before that I was at an event in Twinbrook years ago at which a fella got up and said, "This is a great day. I am no longer obese, I am just overweight." He had come down the chart slightly, and he was delighted with himself. We could know earlier if our children are starting to creep up the scale and do something about it. That information might not be hard to manage, and it would give a parents a bit of help in monitoring children's weight without making an issue of it.

Dr McBride:

Absolutely. We have been working very closely with a number of other Departments on developing a new obesity prevention framework for Northern Ireland. That is with the Executive for consideration and, subject to their approval, we will be launching that in the new year. Thereafter, we will be looking to the Public Health Agency and a range of other partner organisations to develop an implementation plan for taking that forward.

One of the significant reports that the four UK Chief Medical Officers launched a number of months ago was on physical activity guidelines for the entire population. Those guidelines were perhaps unique because, for the first time, we published evidence-based guidance on your dose of physical activity to take per day across the life course. Again, that is unique across Europe and in the States.

The report also contained specific guidance for the nought-to-three-year-olds. Whether your child is crawling or attending a nursery school, it is important to encourage children and give them free, safe space to roll and play and following that all the way through the developmental stages that you outlined. We have targeted programmes in schools. We have been working very closely with the Department of Education to develop a physical activity curriculum for schools. We have been working very closely with schools, given the time that children spend in them, looking at the food in schools strategy with the Department of Education. We have also been working with the Department of Culture and other Departments in the area of sports for all, promoting the importance of all forms of physical activity and encouraging young people to engage in sporting activity.

You will see when that strategy comes out that it has a very structured framework approach, again, engaging with all of the key Departments and other sectors. Then it is over to the very practical suggestion that you have just made about advice, guidance and support to parents when it comes to making the right choices for their children in terms of physical activity and the food that they eat and equipping them with the skills to cook healthy balanced diets for their children. It is about building on the existing support and information that is available and taking that forward.

Mr F Bradley:

I want to emphasise that, in addition to the DHSSPS-led commitments being relevant to a number of other Departments, there are many of their commitments that we see as being relevant to the business of the health and social care system. We have been emphasising that to our arm's-length bodies. There are a number of areas around, for example, poverty — things like tackling underachievement in schools. As you know, we have 2,500 children in care who traditionally do very poorly academically, and we have a lot of initiatives and programmes in place to tackle that. There is a Department of Agriculture one on rural poverty. Even things like waste management and reducing greenhouse gas emissions are

relevant in some way to all Departments.

It is not just the case that those five commitments are all that DHSSPS has an interest in. There are opportunities for us to work in partnership with other Departments and for our agencies to engage in other parts of the commitments that are here, well beyond the five that are marked as DHSSPS-led.

Mr Durkan:

I thank the panel for their presentation and welcome them.

I do not want to turn this into a complete evidence session on obesity. Michael, I am not sure if it was you that coined the phrase, "obesity tsunami", but it conjures up a scary image. Has there been any change in the criteria for diagnoses of obesity that might have led to those huge and dramatic increases in the number of cases?

On the Programme for Government, like other members, I am glad to see the commitments that are in there, but I was alarmed at the shortage of them. I would be a bit paranoid about things and I attributed that, in part, to the pending Compton review. I do not think that any Executive would put something in their Programme for Government about closing residential homes. Now that you have the Compton review, how will it inform the Department's forward thinking and feeding into the Programme for Government? This is just a draft that we have at the moment. There was reference to the plethora of commitments given in the previous Programme for Government. What was the actual success rate? How many of those health-related targets have been hit?

Priority is given to the reduction of health inequalities. Will that be done on a regional basis as well, and, if so, will it be reflected in the budgets allocated to trusts?

Dr McCormick:

I welcome the points that you have made, Mark. Thanks for those. I will take the last one first, if I may.

We have a process whereby social need — as a key factor — is one of the key components of the formula that is used to distribute resources to the local commissioning groups. That is how that works. It is designed to ensure that the money is targeted at need. That is a part of our clear responsibility in relation to many aspects of planning processes. That, in turn, enables the groups to commission services.

As we talked about, at the planning stage the commissioning process should be end-to-end and embrace a full range, from prevention through early intervention. It should not just be a commissioning system focused on buying acute services. It should be comprehensive and broadly based. That is a very important point, and it requires us to face up to the immensely challenging issue of tackling health inequalities as a total system. It is a total system responsibility.

Mr F Bradley:

I will just follow up on the question about our previous achievements. I apologise, I do not

have the information in front of me, but there will be a final delivery report which is being compiled by the Executive. Obviously, all the Departments have been feeding into it. I can find out for the Committee and come back. I do not think that that report has been released yet, though I am not 100% sure.

Dr McCormick:

On the application of the issues arising from the health and social care review, there is an opportunity for that to be considered, given that this is a draft Programme for Government. We need to draw that to the centre's attention in the next number of weeks as that consultation unfolds and see if there is a desire to amend or adapt some of the main thrusts of the proposals for change. That is well worth considering. I certainly welcome your point on that. That is something we will look into, subject to what the Minister thinks. If he wants to put that forward as part of a proposal for amendment and development, there is plenty of scope there.

Ms Julie Thompson (Department of Health, Social Services and Public Safety):

There is already an existing Programme for Government commitment to:

"reconfigure our network of health and social care services to improve patient outcomes and access to new treatments".

I suppose that the overarching catch-all is there, and we can certainly consider putting other things underneath it if necessary.

The Chairperson:

Do you think the point Mark made about health inequalities is adequately covered?

Dr McBride:

Let me be very clear and blunt about health inequalities: we have singularly failed to address them. We have not narrowed the gap in life expectancy between the most deprived and least deprived parts of Northern Ireland. That is repeated, irrespective of what public health issue you look at — rates of smoking, levels of obesity or how long you live. I have repeated that in my report year in, year out. If anything, the gap in life expectancy is growing. On average, it is about seven years for men and five for women. We are not unique in that, either in the United Kingdom or across the developed world. We have been singularly unsuccessful in

addressing that issue.

The draft Programme for Government focuses on that public health agenda. As Julie has just indicated, we have an opportunity to weave into the document an approach to how we reconfigure services and re-orientate them more towards disease prevention. It is not just about what the Public Health Agency is doing, but about what the health service, doctors, nurses and other health professionals are doing to prevent the causes of ill health. We cannot continue to patch people up and send them out again into the same circumstances that made them unwell in the first place. It is about a fundamental re-orientation of what we do in health and how we work with other Departments in addressing those issues across the whole of Government and how the health service is geared towards addressing people living with long-term conditions, because more of us are living longer with more long-term conditions. That requires a different sort of health service, pattern of services and level of care, which you covered in your last session. It also requires a health service that is more geared towards promoting the right sorts of behaviours and for Government to create the circumstances through education, information and, where necessary, legislation to empower people to make those right decisions and choices.

Mr Durkan:

Have the diagnoses of obesity changed?

Dr McBride:

No. World Health Organization (WHO) criteria on pre-obesity and obesity have not changed. For pre-obese, your BMI is between 25 and 29·9, and a person with a BMI over 30 is classified as obese. I did not coin the phrase "obesity tsunami". In 2006, I referred to the "obesity ticking time bomb", which was front page in the 'Belfast Telegraph'. That was my catchphrase at that time.

Mr Durkan:

With the tsunami one, I cannot help but think of someone with obesity jumping into a swimming pool.

Dr McBride:

The ticking time bomb is still ticking. There are some encouraging signs that we have reduced the rate of increase. We now need to address the significant challenge of the levels of obesity.

Mr Brady:

Thanks very much for the presentation. Fergal mentioned initiatives led by other Departments that impact on health. OFMDFM is committed to delivering a range of measures to tackle poverty and social exclusion. Priority 2 in the draft Programme for Government talks about:

"Creating Opportunities, Tackling Disadvantage and Improving Health and Well-Being".

During the period of the Programme for Government from 2011-15, the so-called welfare reforms will be upon us and are certain to be implemented within the next couple of years. That will increase poverty and disadvantage, put marginalised people into a worse position and create homelessness. The migration of 76,000 people from incapacity benefit to jobseeker's allowance over three years has already started. Figures out today state that approximately 61,000 people are unemployed, and that is likely to get worse. More and more people will become dependent on

benefit with changes from disability living allowance to personal independence payments. Carers will also be affected. Probably £500 million to £600 million will be taken out of the social security budget in the North.

How do you think those issues can be addressed if welfare reform takes hold, as it has already started to take hold? With the single room rent and the change in age, approximately 6,000 people could well become homeless in the next year. That is going to kick in in January. I am already getting people in the constituency office who are going to be affected. People who have help with their mortgage, retrospectively if they have been on it for two years, that is going to finish in January. Employment support allowance will last for only a year instead of indefinitely if you have particular health problems. How do you factor all that into tackling poverty and disadvantage when you have a Westminster Government intent on increasing poverty and disadvantage? There seems to be a dichotomy in how you address those issues.

Dr McCormick:

There are a range of challenges in dealing with the consequences of decisions taken

elsewhere. We have to project forward the need and impact that that has on the full range of issues from our point of view, which includes the clear association of poverty and ill-health issues for the reasons that Michael passionately talked about. That is an immense challenge. It requires that our energy and resources are focused on those most in need and that we do all the more on prevention. If we let things just run as they are and carry the additional challenges that there will be in society looking ahead a number of years, the consequences for services, if we try just to keep them as they are, will be unmanageable. Therefore, as Michael said, there is a need for a dramatically significant increase in our emphasis on prevention and on early intervention that requires the social care side to be very active in identifying issues for families and children. There is a lot to be said and thought about in that domain. Also, the assessment of needs in relation to care of the elderly will be at the heart of all that goes ahead there.

A further thing that is possible is to see what we can contribute to the kind of economic regeneration and rebalancing of the economy that is at the heart of the whole Programme for Government. That is probably one reason why there is a deliberate and intentional emphasis on rebalancing the economy. If that is successful and we see stronger private sector growth

and so on through some of the developments that are talked about there, then that will counterbalance some of the difficulties on the welfare side. As a set of services in health and social care, we need to do more to contribute to that; we need to be an engine for contributing to economic regeneration.

Last week's announcement co-signed by Ministers Poots and Foster about the work with Invest NI is part of what we are doing; we are contributing through health and social care and research and development. Those are intended to contribute as well, but it is a very complex and challenging set of issues that you raise. I do not underestimate the —

Mr Brady:

The reality is that because of the change in pension age, people who are now nearing 60 who would have qualified for pension credit, which used to be called the minimum income guarantee and was worth approximately £135, will be staying at £67·50, which they will be expected in some cases to use to run a household. If you spend 10% of your income on fuel, that means that you are in fuel poverty, and I am not sure how you reconcile that. It is to be welcomed that some people, particularly cancer patients and people like that, get help with

heating, but last year, 756 older people died from cold-related illnesses because a lot of them could not afford to heat their houses. That is the reality. It is admirable to project all these priorities in health, and that is to be admired and appreciated, but there will be people who are sinking deeper and deeper.

One issue discussed was that of obesity, and one of the reasons is because of food and lifestyle. If you have £67·50 on which to run a household, you will be going for cheaper types of food. I accept that it is complex and we do not necessarily have that much control, but that has to be factored in. We cannot develop policies that are being totally counteracted by what is happening in Westminster. That needs to be factored in.

Dr McBride:

Your points are well made. As Andrew indicated, you have very succinctly highlighted the strong links between poverty and poor outcomes and health. There is also very strong research evidence on a strong economy and better health outcomes. If you look at evidence from the WHO and the World Bank, you can see, for each percentage increase in GDP, improved health outcomes across a range of measures. That goes back to our discussion

about the centrality of the Programme for Government. We need to see the joins between a strong, vibrant economy and a healthy population, because with that will come employment.

Take one example — for instance, the challenge that we face with suicide in Northern Ireland. Last year, 313 people lost their lives through suicide. It is two to three times more common in areas of deprivation. I do not need to tell anyone around this table that; you will see the impacts in your communities. The variation in the areas that are most deprived is very significant. It ranges from something like 24 per 100,000 down to rates of seven or eight per 100,000. Again, that is strongly linked to deprivation, particularly economic deprivation. Research shows that for every 1% increase in unemployment there will be a 0·79% increase in the rates of suicide in the society. That is the scale of the problem that we are facing. I do not want to underplay the wider economic aspects that you have highlighted. People's spending power and the money that they have in their pockets allows them to make decisions. We need to create the circumstances whereby we regenerate, as Andrew said, and rebalance the economy, so that we have a strong economy and we see the strong advantages for the health population through so doing. That is vital if we are to begin to address some of the stark differences in life expectancy that we see and which we have just discussed.

Deprivation and poverty are at the root of that.

Mr Brady:

Just to finish, I absolutely agree with what you are saying about a strong economy, but the reality is that the biggest change in the welfare state since 1948 is being introduced during one of the worst recessions that Britain or this part of the world has experienced. In terms of how people manage, we have higher rates of mental health problems, particularly among young people, and one of the highest suicide rates in western Europe in this small part of the world. All those issues need to be addressed, but by reducing people's ability to get out of that situation, surely by definition it is going to increase. That is the issue. Obviously, you cannot solve the problem of the welfare state in that sense, but those are issues that need to be addressed if we are going to have priorities and say that this is something that we need to do. At the back of all this, people are suffering; carers, older people, young people, everybody. There are young people in my constituency who are working for £5 on top of their benefits. That cannot be right, and it is no incentive. It probably contributes, in many cases, to making their situation much worse than it should be.

The Chairperson:

That was a very compelling contribution, Michael. I did not get to ask a question in the House because I was late to the Programme for Government debate, but I asked that question of the Minister of Enterprise, Trade and Investment when she was up straight after that. I asked her what discussions she had had with the Health Minister about health inequalities and life expectancy. The answer was not very impressive. Perhaps that is a piece of work that the Health Department could bring up with the Department of Enterprise, Trade and Investment; you could put it to the Enterprise Minister that the correlation between economic disadvantage and health is so stark that she cannot ignore it. That discussion should happen, I believe.

Dr McBride:

I assure you that the Minister wrote to the Committee and the Executive back in June to highlight the fact that there had been very significant discussion about the development of the successor strategy to Investing for Health, which is about addressing the root causes of health inequalities and poor health, the socio-economic factors and education issues, and the differences in life opportunities that people have. That process was signed off by the

ministerial group on public health, on which all Departments were represented and on which they all played a very active part in signing up to the review of Investing for Health. Indeed, prior to that and subsequently, the Minister held a series of bilateral engagements with other Ministers, supported by officials. There has been broad support for the development of the successor strategy to Investing for Health. The Minister has also set a very challenging timeline for the finalisation of the successor strategy so that it can go to the Executive in the spring with a view to going out to consultation and having a replacement strategy in place by 2012. Given the very challenges that you have mentioned, we need to get serious about public health and the context in which we now find ourselves.

Dr McCormick:

We look to other Departments to contribute to that. We also contribute to their key commitments in the Programme for Government. You are well aware of what the Department for Social Development is committed to doing in the Programme for Government, on fuel poverty and affordable housing and so on. Those are complementary, but that does not take away from the extent and severity of the challenges.

Mr Dunne:

Most of the issues have been covered. Following the Compton report, which has taken up a lot of our time this week, do you feel that the five priorities are still fit for purpose?

Dr McCormick:

As Julie said a short time ago, there is some scope to develop the particular commitment on service change. That provides some considerable scope. There is room to consider that further. We have only just received the review. It is right to work with the Minister to consider whether the five commitments and the milestones underneath them can be developed further.

Mr Dunne:

They are still open for public consultation, so I take it that you will review them in relation to the Compton report.

Dr McCormick:

We will look at them and take account of the views that come to us as part of our consultation process.

Mr Dunne:

Is the Compton report a priority driver for the five points?

Dr McCormick:

Not formally, as such, in the Programme for Government context, but it is undoubtedly a major driver in the development of the plans for change across health and social care. It is self-evidently very significant in that context. The question is how to reflect that properly in the commitments and milestones as they are finalised from 22 February, when the consultation closes.

Ms Thompson:

There is a huge consistency between what is in the draft and the 'Transforming Your Care'

document. It is a matter of building on that and seeing where the Minister wants to take that as we look forward.

The Chairperson:

We suspect that that is why the performance and efficiency delivery unit stuff has not come to us yet.

Mr McCallister:

Some of the phrases used are "Enhance access to life-enhancing drugs" and reducing bed times compared to 2010 by 10%. Why did you pick that year? Furthermore, it refers to improving access to cardiac treatments. Some of them are quite loose terms and are not especially aspirational. Was it deliberate policy not to commit too heavily? Those do not seem to be particularly strongly worded phrases or heavy commitments.

Dr McCormick:

The commitments require us to be quite specific. There is a fair degree of direct obligation to

fulfil them. They are quite specific year by year. Some other parts of the Programme for Government simply repeat the same point for each of the three years. Ours have different things and different timetables so that we can maximise the particular impact.

Ms Thompson:

As Andrew has indicated, the detail around the one that you have picked about the drugs or whatever will be specified in the commissioning plan direction for the service as we get down to that level of detail. As was said in the opening remarks, this all has to be subject to monitoring. Therefore, we need to be clear about what we are monitoring against what targets. That work will follow through in terms of making those milestones specific to particular achievements.

Dr McBride:

There is remarkable consistency between the commitments and the principles, values and strategic direction that are outlined in the health and social care (HSC) review, which you have just been discussing. Both indicate the need for a strong focus on public health, prevention and early intervention. I am just noting some of them. There is a big emphasis on

the fact that we need to change the healthcare system to one that concentrates on supporting people with long-term conditions to live independently. There is also an emphasis on self-management and education programmes to empower people to do that, and the importance of quality at the centre of that to determine how services should look and be shaped, and patient choice for care closer to home. The use of technology, which Andrew alluded to, in terms of connected health and using technology to support people with long-term conditions at home and pre-emptive care to anticipate when their condition may be deteriorating to avoid hospital admission. It is perhaps not surprising. We talked about deprivation. The commitment here, and as highlighted in the review, is to family nurse partnerships and the use of evidence-based processes to support single young mothers.

It is very reassuring that there is broad consistency in the messages, both those that we have identified and those currently outlined in the draft Programme for Government, and in the review that we have just discussed at length. There should not be any surprises or major omissions. So, the strategic direction, going back to Gordon's question, of the health and social care review is entirely consistent with the priorities that have been outlined in the Programme for Government. There will be a strong alignment of those. As Julie has said, the

specific detail of what that will translate into will be outlined in the commissioning plan in due course.

The Chairperson:

Key commitment 1 says:

"Allocate an increasing percentage of the overall health budget to public health",

but the milestones for the following years are in monetary values: £5 million, £7·5 million and £10 million. Is that meant to confuse us or the public, or is it just sloppy? You talk about increasing the percentage but there is no baseline for public health. You increase it by £5 million, but the baseline might only have been £1. I am being a wee bit facetious, maybe. However, it is not very tidy in terms of presentation.

Ms Thompson:

It is intended to make it more meaningful for people. Look at the commitments in a large portion of the Programme for Government: a lot of it is about moneys being invested in particular programmes. So it keeps that consistency, and makes it more meaningful to the

public. If you talk in percentage terms, people might not understand how much money you were talking about. Those sums are compared against the spend in the 2011-12 year and increasing from that. So it was intended to translate a percentage figure into an actual amount of physical cash that people might understand easier. That is consistent with a lot of the other commitments, which are done in exactly the same way.

The Chairperson:

The fact that the baseline is not there — an increase in percentage, and then the figures. It would have helped if we had started off with the baseline figure first. Then, what is being put in additionally would be more transparent and allow people to understand it better. The way that is done just seems to be a wee bit duplicitous.

Mr McCallister:

Or the percentages in brackets after it.

The Chairperson:

Something to make it easier to understand. I find that actually more confusing than what you were trying to do, Julie.

Dr McCormick:

Do you want to give some more numbers?

Ms Thompson:

The level of anticipated spend on public health in 2011-12 is £119 million. The £5 million, £7·5 million and £10 million will go on top of whatever turns out to be the 2011-12 spend. It will be monitored — the monitoring mechanisms have already been talked about — and, therefore, will translate into a percentage increase. We could have put both in, I suppose. Would that have helped? I am not sure. It was deliberately put in that way to make it clear to people what sums of money we are talking about. We know the base; it is there and it will be monitored against that. There will be that clarity.

Dr McCormick:

It would help if we send a letter just to record those facts and confirm them. We are not trying to hide anything. As Julie said, we are trying to give a straightforward presentation of the facts. If you find something else more helpful, we can do that. There is no problem at all with that.

The Chairperson:

Given that this is a public document, that would be helpful. If we are querying it, you can be sure. I am glad to hear that you know what the base is, because that was one of the discussions that we had earlier in the year, when we were confused about the tables of figures that we got from the Department and why they did not add up. We are very keen to see what has been spent on public health and we accept the key role of early intervention and prevention. That is something that you may want to take forward for the future.

I also want to put down a marker that we want to see the role of the PHA shored up, and we hope to have it in for a session on that as well. I would not like to see any dilution of the work that it does. I have been lucky to be the accompanying Minister at a number of

North/South Ministerial Council meetings where Safefood showed what it is doing across the island — things like reducing salt intake on obesity, etc. I also want to send a strong message that the work that Safefood does is very valued in terms of getting the messages out consistently across the island of Ireland. I think that they both have a role to play, and I would like to see that ongoing in the future.

This has been a useful session. Unless anyone wants to come in on any other questions, I am going to draw it to a close. Given the discussion at the beginning of the session about the commissioning direction, I know it is under way for this year, but can we get an assurance today that this Committee will be consulted on the commissioning direction for 2012-13, given that the PFG was not as weighty as we expected it to be in terms of the direction? The commissioning direction is obviously a very important piece of work, and it would be helpful if the Committee was consulted while it is still in draft form as opposed to getting it when it is completed. Can you give the assurance today that we will be included in that?

Dr McCormick:

Subject to the Minister's views, we will be glad to come back to you on that during January,

because that is work that has to move on very quickly now to enable the actual development of the commissioning plan. Time is quite short to do that in a proper, orderly fashion to get implementation of a new process from 1 April 2012, but there is no difficulty whatsoever in formal engagement with the Committee on that in the next six weeks. Time is very short, but I will just have to defer to the Minister on the precise process there, if that is OK.

The Chairperson:

OK. I would like to ask something before you go. I suppose, Michael, I am being a bit cheeky by jumping in on this. In relation to the changes to the cervical screening programme, are we going to the quadrivalent vaccine? Did I hear that we are going from the two-dose vaccine to the four-dose vaccine?

Dr McCormick:

I cannot recall whether there has been an announcement on that, so you have me over a barrel. As you know, it was re-tendered. The human papilloma virus (HPV) vaccine that we were using from year-9 schoolgirls upwards was specifically targeting types 16 and 18. That obviously went out for tender again, and the Department of Health in London was leading on

that tendering process. I am not clear whether there has been an announcement on the successful tender.

The Chairperson:

I am not sure whether it was something that I was hoping for or that I imagined. Paula, did you say that there was an announcement?

Ms P Bradley:

I do not recall an announcement, but I think it has been well talked about.

Dr McBride:

There is a decision. I am not certain whether there has been an announcement, but I am happy to clarify that by writing to you in due course.

The Chairperson:

I know that the NHS list prices of the two were similar. Whatever negotiation was done, we ended up having access to the lesser vaccine. I know that they use the quadrivalent one in the rest of Ireland, so there is a wee inequality there. I hope that a strong message can go to the Department of Health that we want to use the quadrivalent one. I do not know if there have been any discussions, but I know that at the moment it is offered to girls and the uptake of the screening programme has been very successful. Michael, are there any views on offering it to boys as well? I know that HPV causes more than cervical cancer. There are quite a number of cancers connected to the HPV virus that could be prevented if boys were vaccinated as well.

Dr McBride:

I will pick up a couple of points there. Obviously the Minister takes advice, as, indeed, do all Health Ministers across the UK, from the National Screening Committee about the cost-effectiveness of screening programmes and from the Joint Committee on Vaccination and Immunisation (JVCI) on vaccination programmes. The JVCI will look at all of the evidence and the cost-benefit analysis. The decision to vaccinate girls starting in year 9, and with a

catch-up vaccine from 2008, was based on a cost-benefit analysis looking at the prevention of cervical cancer. The vaccine itself is primarily about preventing cervical cancer. It prevents about 70% of cases of cervical cancer, not all cases. Some 30% of cases will not be prevented, and that is why it is vitally important that the 23% of women in Northern Ireland who do not currently come for the regular cervical smear do so. We know of 80 cervical cancers diagnosed each year here in Northern Ireland, and 50% of those 80 women have not been attending for regular cervical cytology. That is an important message to get across.

There was significant lobbying on using the alternative vaccine because HPV causes anogenital warts. They are implicated as a causative factor in cervical cancer, which causes a huge burden of disease, pain and distress for individuals who acquire it. The Joint Committee on Vaccination and Immunisation, and the Department of Health, went through a proper tendering process that will look at all the evidence on the effectiveness of a vaccine and its cost-effectiveness. There are robust arrangements around that tendering process, including confidentiality, to ensure that the outcome is the correct one. While I know that a decision has been reached, I am not sure whether that decision has been communicated, so apologies for not being able to share that with you at this stage but I am happy to write to the

Committee in due course.

The Chairperson:

A number of babies contract genital warts before birth, and the process of removing them is horrendous for the parents and the child. Presumably, all that information was taken into consideration. However, there are penile cancers, anal cancers and oral cancers connected to HPV. It would be beneficial if the evidence base looked at the effectiveness for boys. Some of us are too old to have got the vaccine. Therefore, screening is important. We would like to see the pilot in the Western Board area to be available for everybody so that there are better outcomes and a better pathway for success and the invasiveness of the screening regime.

Dr McBride:

The National Screening Committee looked at, and is currently looking at, the HPV triage. There is no doubt that there is evidence to indicate that it would have a significant benefit in selecting out those women who have an abnormal smear and who would, perhaps, benefit from earlier referral to colposcopy and follow-up. More important is to reassure those women who have had treatment that the HPV was eradicated and they can return to normal screening.

We are looking at that across the UK and we will take the expert scientific advice on the usefulness of that.

We will also have to look at the service implications. If we were to introduce that, what would it mean in increased demands on colposcopy services and cost implications? There is still work to be carried out on the effectiveness of the particular test. A number of HPV tests are available and are being assessed. I wrote to the chief executive of the Public Health Agency some months ago asking the agency to look at scoping the potential for introducing HPV testing in Northern Ireland and the likely impact that it would have on services and the associated costs. We are very live to that issue and actively looking at it.

The Chairperson:

Hopefully, the outcomes can be balanced with cost. If you are a young woman who has got a life sentence or a life-limiting condition because it was not caught in time and you are likely to end up with very bad news, that has to be factored into all of it as well.

Dr McBride:

Those are vitally important conversations and considerations in all this.

The Chairperson:

I am sorry for bouncing you on that, Michael, but I just wanted to get that off my chest. I am very anxious that the proper immunisation and screening is carried out. That is the right thing to do.

Dr McBride:

It is hugely important, and I thank you for raising it. It is important that the Committee continues to have a very active interest in the whole area of prevention and screening, and immunisation where appropriate. It is excellent that this year we will see the introduction of yet another screening programme for men over 65 years old with the potential for aortic aneurysm. That programme will prevent 40 deaths per year. The Minister announced this week that we are extending the bowel cancer screening programme. We have also had a very successful introduction of the HPV vaccine programme. That will prevent people from dying from cancer. An important message is coming from the Committee today about encouraging

women and others who are offered the opportunity of screening, whether bowel cancer screening or cervical screening, to avail themselves of that opportunity because it does save lives.

The Chairperson:

We also want to encourage uptake of the vaccine, and would encourage as many girls as possible to get vaccinated. Thanks a million, and happy Christmas to all of you.