Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Resource Spend: 2011-12

25 January 2012

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 Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Ms Pamela Lewis
Mr John McCallister
Mr Kieran McCarthy
Ms Sue Ramsey

Witnesses:

Ms Christine Jendoubi	Department of Health, Social Services and Public Safety
Ms Julie Thompson	Department of Health, Social Services and Public Safety
Mr Peter Toogood	Department of Health, Social Services and Public Safety

The Deputy Chairperson: I welcome the team, who are all veterans of the Committee: Julie Thompson, deputy secretary of resources and performance management in the Department; Peter Toogood, director of finance, who has been with us many times recently; and Christine Jendoubi, who has been with us perhaps the most —

Mr Dunne: Every week. *[Laughter.]*

The Deputy Chairperson: Yes, every week, wearing various hats in the Department. Christine is director of mental health, disability and older people policy. I ask the witnesses to make their usual presentation, after which I will throw open the floor to members for questions.

Ms Julie Thompson (Department of Health, Social Services and Public Safety): I thank you for the opportunity to provide evidence to the Committee on planned expenditure for the 2011-12 financial year. Our comments will be based on the strategic resources framework (SRF) document for 2011-12.

The purpose of the SRF is to provide details on how the Department and our organisations plan to spend the funding that they have been allocated for a financial year. The SRF highlights the Department's spend by nine programmes of care, such as acute services, elderly care and health promotion, and other key services, such as general medical services (GMS), dental and pharmacy. The

planned spend is analysed on a geographical basis, and information is provided on general outcome measures, such as suicide, obesity and teenage pregnancy rates, et cetera.

At previous Committee meetings, we discussed the range of financial information produced by the Department and the purposes for which it is used. We also discussed the different bases on which that information is prepared. Members will recall that it is a particularly complex area; therefore it might be helpful if I recap on the bases on which the SRF is compiled.

The SRF is an analysis of recurrent funding made available to the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) at the outset of the financial year. It does not include any recurrent funding issued during the year, any non-recurrent funding issued to the board, capital charges or direct running costs of the Department or other arm's-length bodies. It is there to provide trends for the planned expenditure on a similar basis from one year to the next. Caution needs to be exercised when comparing that information with actual expenditure. We went through that with the Committee in September and October of last year. The expenditure includes non-recurrent funding and expenditure against income from non-departmental sources, such as private patients.

Against that background, I will outline some of the key areas of spend in the SRF for 2011-12. The total planned expenditure for the whole Department amounts to some £4·6 billion, including capital. Eighty-five per cent of it is allocated to the HSCB and PHA to purchase hospital services and community and personal social services, which is about £3 billion, and delivering family health services, which is about £800 million. Those amounts represent an increase of 3·5% from planned spend in 2010-11. I will now highlight some of the key expenditures in that analysis. Members will note that the acute services programme of care amounts to some £1·3 billion, or 43% of the total planned spend. It includes accident and emergency, surgical and medical procedures, and, as such, represents a significant proportion of the services that are provided by the HSCB.

Elderly care is the second largest area of expenditure and accounts for 21% of our total spend; it captures spend across the hospital, community and PSS sectors on elderly care. We also have the health promotion programme of care, which received a significant increase between 2010-11 and 2011-12. The Minister is committed to increasing health promotion spend, which is evident in the draft Programme for Government and the forthcoming development of a new public health framework. Family health services represent expenditure of some £800 million; approximately half of that is spent on pharmacy drugs. That area also includes planned expenditure of £228 million on general medical services.

Health and social care is commissioned across five local commissioning groups (LCGs). The level of funding for each area will depend on the size of its population, its age and gender profile and its level of need. In overall terms, the level of funding that is allocated by LCGs increased by 3·5% between the two years.

I understand that, last week, members raised concerns about child and adolescent mental health services (CAMHS) expenditure and wanted that picked up today. Recent reviews have observed that mental health services, including child and adolescent mental health services, are underfunded: Bamford highlighted a level of underfunding of some 25%. The 2011 Regulation and Quality Improvement Authority (RQIA) review of CAMHS identified aspects that needed further improvement; tier-2 services were highlighted as requiring further development. Notwithstanding the challenges in that area, the Department endeavours to ensure that resources are used in the right way and that money is spent on the right things while enhancing the overall quality of care and patient experience. As a consequence, it is encouraging to note that no young person has had to be transferred outside Northern Ireland for treatment for an eating disorder in the past two years. In addition, the Health and Social Care Board has a child and adolescent mental health services subgroup to oversee and manage the implementation of the Bamford and RQIA recommendations. That subgroup comprises representatives from the HSCB, users and carers, education and juvenile justice. The Department will also shortly consult on a regional service model for the development of CAMHS, as recommended by RQIA.

I trust that this briefing has been helpful in providing an overview of the elements of the planned spend for 2011-12. I am happy to take any questions.

The Deputy Chairperson: Thank you very much, Julie. This might be a bit unusual: I might start my questions as the Chairman and finish them as a humble Back-Bencher. Having looked at the tables, Julie, I see that you are delivering very much to plan. Am I right in thinking that the books will balance this year?

Ms Thompson: That is our understanding. If you recall, I was here just before Christmas. Our current forecast is that we will balance the books by the end of the financial year.

The Deputy Chairperson: This time last year there were tales of gloom and doom: there would be 4,000 compulsory redundancies and the Department was at chapter 9 and heading towards insolvency. Yet here we are a year later and you are telling us that — as a result, I suspect, of a great deal of hard work and considerable pain — you have managed to balance the books. Is that a true reflection of what has happened?

Ms Thompson: There is a combination of issues, which we discussed through the autumn. There has been a range of measures and, as you said, hard work in trying to reduce the outstanding gap that we had from the start of the financial year. We talked about extra savings in pharmacy and the Fire and Rescue Service and have been right across the budget to reduce expenditure. In the autumn, we also talked about the impact that balancing the books has had on patient care and that waiting lists and times have been extending during 2011-12. Although the books have been balancing, there has been an implication for patient services.

The Deputy Chairperson: Have there been any compulsory redundancies to achieve that?

Ms Thompson: No.

The Deputy Chairperson: How many positions have been frozen and not filled?

Ms Thompson: I do not have the information about what has happened in the workforce with me, but the trusts have managed that locally with the workforce that they have. That has led to the balancing of the books.

The Deputy Chairperson: The most recent figure showed that about 2,000 positions were unfilled. That was midway through the year, and I do not know whether any further posts have been frozen. However, no one has been asked to leave when they did not want to go.

Ms Thompson: That is right.

The Deputy Chairperson: That is quite an achievement, given the restrictive budget that you are under. Having achieved that, the problem is that you now have to start all over again and take further savings out of the budget because of the increase in growth. Have you any thoughts about how feasible that is?

Ms Thompson: We are looking not only at the 2012-13 budget but through to the end of the budget period. You are right that the pressures are significant, and we are working with the board and the trusts to get an accurate quantification of the scale of the pressures in play. We are also looking at the opportunities or the savings that might need to be put in place to manage that financial position. That will work through in the next few weeks; and, in the not too distant future, we hope to be in a clearer position about what that will look like. However, a great deal of work is ongoing around that as we look at 2012-13.

Mr McCarthy: Thank you for your presentation. Paragraph 5.4 "Anxiety and Mood Disorders, Northern Ireland 2008" states that:

"The numbers of individuals suffering from anxiety and mood disorders is produced using prescription data to estimate the numbers that have been prescribed the relevant drugs."

How do you measure the number of people who are not on prescription drugs?

Ms Thompson: The estimate is only about people who are on prescription drugs. Christine might be able to talk more about the talking therapy side.

Ms Christine Jendoubi (Department of Health, Social Services and Public Safety): The simple answer is that we do not keep a running tally on anxiety and stress per se. The trusts and the board know numbers, which I do not have with me, I am afraid, of overall mental health problems but not those specifically. We are not sure where the table in the strategic resources framework document came from or why that condition was singled out for attention across the trust areas.

Mr McCarthy: What about the dates? The information is for 2008, yet there is a table for suicide rates for 2009-2010. The document states that non-recurrent funding is targeted at areas with high rates of suicide and is allocated based on prevalence rates in parliamentary constituencies. However, the data on suicide rates in chart 8 is broken down by the 26 local government areas. Why allocate funding based on parliamentary constituencies if the rate is measured by local government area? Surely, that does not allow for measurement on the impact of non-recurrent funding.

Ms Thompson: The money allocated there comes from the LCGs based on how they allocate their funds. As you said, they allocate funding to areas based on where there have been particularly high rates of suicide. You can break the data right down to local government districts and pull it from there. We can also match the data at that level to parliamentary constituencies so that the tally can be done. The document explains that an element of the funding is targeted at areas of higher rates of suicide.

Mr McCarthy: The chart shows that only four areas have seen a drop in rates: Ards, Ballymena, Banbridge and Down. Are those four areas doing something right? Can other areas learn from them in order to reduce their suicide rates?

Ms Thompson: Suicide is a complex issue. A great deal of work is ongoing and significant investment has been made in suicide prevention; in targeting, general awareness, education and working with the voluntary and community sector. To answer your question on whether those areas are doing something particularly different, I am not aware that they are. Resources are being focused where they need to be focused.

(The Chairperson in the Chair)

Ms S Ramsey: Kieran raises a valid point. It goes back to the discussion that we had earlier about North Down. It is about targeting resources. Although an area in my constituency is inside the Westminster boundary, part of it belongs to Lisburn City Council. Over the past number of years, the suicide rate in that area — the Colin area — has increased. You say that money is being targeted. My concern is that there is a suggestion and, possibly, evidence that although money has been allocated to health in the Colin area because of the increase in suicides in it, it does not necessarily go to the Colin area. It goes to different parts of the council area. That has raised concern. It might be useful to explain why money is allocated by council area and what the difference is between it and the Westminster constituency. That probably applies to areas of North Belfast as well. Ministers, Departments and the Executive say that they will take action in areas where suicide rates have increased. However, when it comes to getting money on the ground, it is not targeted where it should be because of that strategy.

Ms Thompson: That comes from the local commissioning groups. I understand exactly what —

Ms S Ramsey: There are two local commissioning groups as well.

Ms Thompson: Yes. I understand what you are saying. They need to identify where there is need and invest the money where it is best placed. Suicide is much more than just a health issue; many other issues come into play. With regard to what LCGs are doing and whether they are investing in the right places to maximum effect, I understand fully what you are saying about ensuring that money ends up in the right services.

Ms S Ramsey: We need to take on board how close Westminster constituencies and local government constituencies are: an area could be divided by one street and the two parts be in different constituencies. A suicide has a big impact on an area, regardless of the constituency it is in.

Ms Thompson: I appreciate that.

Mr Dunne: It is good to see you back. I want to discuss the key findings for programmes of care. I understand that we have committed to an increased budget for mental health. The budget for 2011-12 is slightly lower than that of the previous year. Will we see an upward trend, all being well, for mental health in the coming year?

Ms Thompson: The planned spend for mental health is up by some £3 million in 2011-12 compared with that of 2010-11, although the analysis for 2012-13 has yet to happen. It needs to be worked through. However, there has been an increase. The drop to which, I believe, you are referring occurred between 2009-2010 and 2010-11. There certainly was a drop between those years, although the budget increased in 2011-12.

Mr Dunne: The "Key Findings" section of the framework shows a slight reduction in the mental health budget.

Mr Wells: In percentage terms, it is a reduction.

Ms Thompson: In overall monetary terms, it went up from £232 million in 2010-11 to £235 million in 2011-12, so there was an increase in the investment. When we were here in the autumn, the Committee was concerned about the drop in 2010-11; however, that drop has been reversed for 2011-12. I am not sure if you are asking about the percentage of the overall budget, but the actual investment has increased.

Mr Dunne: The other point is about the pharmacy budget. Drugs make up 50% of the budget.

The Chairperson: Sorry to interrupt, Gordon, but before you move on to the pharmacy budget, I want to make a point. The Committee has been consistently concerned about the spending on mental health and the priority that it is given in the Department. It is still unacceptable that so little is spent on mental health when you see the devastating consequences of not getting it right.

It is interesting that Christine made the point that the mood and anxiety disorder chart is in this paper. The paper is difficult to follow and a wee bit confusing. There are different methods of evidence gathering used for different areas, so one thing has a three-year strategy, something else has a one-year strategy, and something else has a five-year strategy. The word that we would use to describe it in the Brantry is "throughother". This paper is throughother; it is hard understand how targeted you are. It seems that things have been picked out and included in the paper because they look like good news, yet the underlying problem is that not enough money is being spent on mental health and we are not getting to the nub of the problem.

The percentage spend on mental health in 2010-11 was 8%; in 2011-12, it went down slightly to 7·79%. The Committee has been consistent in saying that that is not enough, given the problems that we have. That is the case regardless of whether the suicide rates are factored in or whether the mood and anxiety disorder graph is included or whether people are missed out entirely on mental health spending and end up as suicide statistics.

This document does not allow us to probe the issues, the spend and the priorities in detail. John asked last week about spending on CAMHS, but it is hard to get to the nub of spending in the Department from this document, because the framework seems to be a conglomeration of different figures. It does not seem as though one person took responsibility for it from start to finish and proof-read it. It does not read properly, and it is very difficult to get the information that we need out of it.

Ms Thompson: I appreciate that it is an exceptionally complex area.

The Chairperson: Made more complicated by a bit of creative writing.

Ms Thompson: In the paper, you are trying to analyse £3 billion of expenditure, draw from it where spend is and how it is planned to follow. The paper is one element: we also have the commissioning plan direction on the targets that are set in it and the accompanying commissioning plan. Therefore it would be wrong to say that the paper is the only document that exists to explain what is happening in the service.

The Chairperson: We were told that officials would be available to brief us on elements of the commissioning plan, but we have not been told yet that we are getting the actual commissioning plan. We have asked for it and have said that we will put the meeting with officials back by a week if it means that we get sight of the document. Again, when you dig into this, mental health is being de-prioritised; it is being given less funding for 2011-12 than it had in 2010-11. That is a worry. Many of the decisions are taken before we get the chance to scrutinise them or form an opinion on them. We have had disagreements before — I would prefer that there were none — when the Committee gets inadequate information or when information is not in a format that is easy to understand and extrapolate. The graph seems to be clear that mental health is getting less of a priority than it did last year.

The Minister says consistently that we need to move from acute to primary care, yet we saw the acute figure increase slightly. The Minister says what he says, but when we try to identify what that means in practical terms, we see that spend on acute services is actually going up, spend on mental health services is going down, and health promotion is going up a tiny fraction. That does not equate to what the Minister says publicly. Our job is to take what he says publicly and see what it means for the population that we are here to serve. The figures do not fill us with confidence.

Ms Thompson: You are quite right. I think that you will have a conversation about the commissioning plan direction next week.

The Chairperson: If we get the paper; we will not have a conversation without it.

Ms Thompson: There are issues around whether there is enough pick-up in that of where the targets are; what are the right things that should happen; and on the money side. We also have the Programme for Government material.

The Chairperson: Which you could write on a matchbox.

Ms Thompson: You have expressed that view; I appreciate that. As I said, spend on mental health has gone up by £3 million. However, you are right that it has not gone up by as much as spend in other areas, which is why its relative percentage has gone down from 8% to 7·79%.

The issue is where the mental health budget will be next year. As I explained in the autumn, the exercise is looked at across the piece as an annual exercise. We look at the service of the board and the PHA and then the expenditure. I do not want to give the impression that this is the only thing that is used to manage budgets; we do that by looking at organisations and their spend. A great deal of work goes into it.

However, you are right that this gives underlying trends. The Committee has raised concerns about those trends and about whether you are content that they are going in the right direction.

The Chairperson: I do not think that we are content. Spend on acute services has increased by £57 million from the previous year. Why? It has been a reasonably good year. Fortunately, we have not had a swine flu epidemic. In other years, there have been worse seasonal conditions and possibly a more identifiable need for acute services. Notwithstanding recent problems at Antrim Area Hospital, I do not see the justification for an additional £57 million spend on acute services. You are here to explain that to us.

Mr McCallister: Even the weather has been kinder.

Ms Thompson: Investment in acute services covers a range of things such as NICE drugs, on which investment has increased. It is where expenditure actually falls — capital schemes that open in trusts and additional expenditure in the acute sector. I appreciate what you are saying about too much money going into acute services and that we need to move some of that into other areas. However, the money that is going into the acute sector is for the investments that are being made there aligned to targets, whether on elective care, specialist drugs or new capital schemes. That is what accounts for the £57 million, along with, as you would expect, inflation and pay and non-pay factors that apply to all sectors across the board.

You are reflecting the view that too much is going into acute services. That was picked up in our 'Transforming Your Care' document before Christmas, in which we talk about the need to move from the hospital sector to the community sector and about the shift left agenda. The agenda that you are talking about was picked up in that document and needs to be taken forward.

Mr McCallister: Chairperson, could I —

The Chairperson: I butted in on Gordon because he was talking about mental health and was moving on to pharmacies, and I did not want to let that issue go. So, I apologise, Gordon. Do you want to fire away now?

Mr Dunne: I accept your apology.

The Chairperson: We are waiting with bated breath.

Mr Dunne: I accept your apology without question. Drugs account for about 50% of the budget. We are all, even those of us new to the Committee, very much aware that there has been a drive towards and emphasis on prescribing generic drugs. How much has the switch to generic drugs saved in the past year?

Ms Thompson: We are looking at £30 million in planned pharmacy savings in general in 2011-12 through a combination of initiatives, of which generic prescribing is one, as well as keeping a very tight focus on the trend in prescribing rates.

Mr Dunne: Is that to target? Do you feel that that has come on well compared to recent years?

Ms Thompson: Yes, that is to target.

Mr Dunne: Are you still hoping to improve on that?

Ms Thompson: As I said when Jim was in the Chair, we are looking at savings for 2012-13, so we will certainly be expecting to get more savings out of the pharmacy budget.

Mr Dunne: In December 2009, the trend for the number of outpatients waiting for a first appointment was upwards. To be fair, it dropped off from September 2010 with a trend downwards. Will that trend continue downwards in the next financial year?

Ms Thompson: The number of outpatients waiting was increasing during the 2011-12 year. That goes back to my comments at the start about the implications for services. Obviously, there is a focus on trying to bring those waiting times back down, but they will have increased from that March 2011 level during 2011-12. There is a concerted effort to try to get them back down. As I explained, however, the implications for patients in reaching a financial balance is that it has not been able to maintain some services at previous levels.

Mr Dunne: So, there has been a knock-on effect on services?

Ms Thompson: Yes, but, equally, there has been a tight focus on trying to ensure that targets are achieved and improvements restored.

Mr McCallister: Julie, you are heading in the opposite direction from where Compton was taking us if the spend on acute services is rising. How will you find that 5% that Compton talked about or £80 million when you are going in the opposite direction?

Ms Thompson: That is about putting in place the changes discussed in 'Transforming Your Care'. Doing that, and moving to the shift left agenda, will bring, if you like, a reduction and the move across into the community and personal services. Therefore, as you look forward into 2014-15, that is exactly what needs to happen to fulfill that recommendation.

Mr McCallister: So, if we were sitting here this time next year, you would be expecting to see that figure starting to come down.

Ms Thompson: I suppose it is a question of how quickly these things change.

Mr McCallister: The Minister set three years to implement the review and has asked for £25 million, £25 million and £20 million to do that, so you would need to be starting to make some progress by this time next year.

Ms Thompson: You would, and the issue is then how that translates into the commissioning plan direction that you will be discussing next week as to what can happen in 2012-13 in order to make a start along the way, but it will be a start along the way that then needs to continue as you look forward into 2014-15.

Mr McCallister: That will be very difficult to do when we look at, for example, Antrim Area Hospital and how you manage and deliver that change, given that you are not even holding the line at the moment.

Ms Thompson: And that is exactly where the challenges in priorities are. We have just talked about the implications for outpatients and inpatients. Part of resolving that is around the finance; that requires investment in the acute sector, and the numbers go up. Equally, it requires looking at demand management and what can be done in primary care. That is where the mix within the 'Transforming Your Care' document comes in.

Mr McCallister: Could any settlement on the pharmacy issue significantly knock your budget? Could that cause significant problems, and remember the fact that, when Jim was in the Chair, he was congratulating himself? *[Laughter.]*

Mr Wells: That was not my angle. I had no part in the success of the Department.

Mr McCallister: His colleagues in the Department maybe. No jobs went in that regard.

The Chairperson: It is not my chair he is interested in really. [Laughter.]

Mr McCallister: Edwin, watch out.

If that moves, will it cause you significant problems?

Ms Thompson: We are keeping a very close eye on that.

The Chairperson: But you have not factored it in to the bottom line?

Ms Thompson: We are looking at various assumptions around that and what it could possibly mean. Obviously, that would need to work through its course. I cannot say anything more about it at this stage. We are certainly keeping a very close eye on it.

The Chairperson: Did you want to talk about CAMHS, John?

Mr McCallister: The Bamford review, a number of years ago, recommended that the CAMHS budget should be doubled. Yet we are nowhere near that. Is there any possible good news coming on that, given the earlier questions? I recognise that there has been a very slight rise in the overall spending

on mental health by £3 million but an actual percentage drop in the budget. Where are we going with CAMHS?

Ms Jendoubi: As you said, Mr McCallister, Bamford reckoned on a 10- to 15-year horizon for implementing the recommendations in those 11 reports. As far as mental health is concerned, he recommended a doubling of the budget from, at that time, £200 million to £400 million. That has not happened.

Probably the best assessment of where child and adolescent mental health services is going can be found by looking at the RQIA report that was published in February 2011. That report recognised that there had been considerable improvements in the child and adolescent mental health services across Northern Ireland since Bamford. There are CAMHS teams that cover all five trusts. There are four CAMHS teams, and Belfast covers the south-east as well. All those CAMHS teams have built-in eating disorder skills. We have reached the position where, as Julie said, we are not having to export children and adolescents with eating disorders; we can now deal with them at home. In fact, in the Southern Trust area, they do not have any inpatient beds for eating disorder patients. All eating disorders are dealt with in the community.

Mr McCallister: That is working across the trust?

Ms Jendoubi: That is working, and it is a model that we are trying to roll out in the other trust areas. We have the inpatient facility at Beechcroft, which was opened in 2010. That has taken enormous pressure off inpatient services for adolescents and youngsters. However, we still have about two adolescents in adult beds across Northern Ireland at any one point. Those would be emergency admissions and would mean that Beechcroft was full, on the adolescent end, at that time. Obviously, that is something that we will be working very hard to try to eradicate completely. However, at least the RQIA report did recognise that protocols are now in place in all the adult mental health facilities for dealing separately with adolescents when they come in. For example, they are put on one-to-one staffing and housed in side wards. It is, nevertheless, an inappropriate environment for them.

There is certainly work to do. We want much better progress to be made on personality disorders. We have put money into crisis intervention teams, and that is working quite well now. There are a range of issues that we would like to take forward if we could, but the money is just not there. For example, children make up 24% of the population, but only 6% of the total mental health budget is spent on funding for CAMHS. There is a bit of work to do in addressing that, and, if we were to get additional money into mental health services from any quarter, we would want to concentrate it on CAMHS.

Mr McCallister: Does that leave you stretched, making it very difficult to do any preventive work and early intervention, which can have a big impact on mental health?

Ms Jendoubi: For the whole of mental health?

Mr McCallister: Yes, across the board.

Ms Jendoubi: Yes, it does.

Mr McCallister: It means that you are always firefighting, effectively.

Ms Jendoubi: Yes, the key area that we need to put investment into is basic community psychiatric nursing services. We have done that on the adult side, and we need to do it on the child and adolescent side. We need to organise the services better so that more youngsters are being supported in the community, without a need for inpatient admission.

Mr McCallister: Yes, before they get to the level of needing somewhere such as Beechcroft. You do not see that as likely to happen under the current spending arrangements? You will not have the money to do that, will you?

Ms Jendoubi: We are working towards it, but there is not much prospect of being able to withdraw money from other parts of the mental health budget.

Mr McCallister: At that rate of increase, you are not likely to be able to do so. We have not made a huge inroad into Bamford's recommendation for £200 million doubling to £400 million.

Ms Jendoubi: No, we have not, but 'Transforming Your Care' said that it would take an additional £2 million to implement all of the RQIA recommendations. Even at that, we would want to see services over and above those recommended by RQIA, such as bespoke ADHD services, which we do not have.

The Chairperson: Section 5.9 of the expenditure plans document details child obesity rates in a couple of graphs. Chart 15 shows figures up to 2007-08, and the source is the information and analysis directorate of the child health system. Those are not our statistics but London figures, are they not?

Ms Thompson: They are certainly based on Northern Ireland children. The information came from inside the Department, from the child health system.

The Chairperson: Just because it came from inside the Department, Julie, does not necessarily mean that someone did not do a wee desktop exercise. I am a mother of young children, and I do not know that —

Mr Wells: Three.

The Chairperson: Thanks, Jim, that is very good of you.

Mr Wells: You seemed to have forgotten.

The Chairperson: No, No.

The document states that the graph sets out the percentage of children between four and a half and five and a half who are overweight or obese, but I do not know whether those children have ever been put on a scale and weighed. Therefore, I am curious about where the figures come from, and I am perturbed that the graph only goes up to 2007-08 when we are now in 2012, albeit the start of it. Are those figures not a bit out of date? Are we dealing with figures that have been collected here or figures that were collected somewhere else?

Ms Thompson: My understanding is that they were collected here and that that is based on primary 1 children. Those measurements are taken in schools. I also know that it is coming through in the annual health survey which is done across the population. One of the questions in that is: if there are children in the house, what weight and height are they? You may not have had a visit from —

The Chairperson: Is that a random survey, or is it done through GPs or schools?

Ms Thompson: It is done by the Northern Ireland Statistics and Research Agency (NISRA), so it is done on a random basis, but it is a proper statistical survey done across the population. It deals with a whole range of issues, but one of the questions is about children.

The Chairperson: I am just curious, because I have never been asked to weigh my children to find out if they are part of those figures.

Ms Thompson: I am speaking from personal experience, because I was.

The Chairperson: OK. Do you know why the figures are so out of date? They are from 2007-08. Does that not strike you as a bit strange?

Ms Thompson: I would need to check the detail of that, but my understanding is that they come from the times when they were being weighed in school. I would need to confirm whether they are still doing that or not. I will come back to the Committee on that, because I am not au fait with it. It must have been the most up-to-date data that we had, but I cannot say why it is not more up to date.

The Chairperson: I do not know whether that worries me more or less. If we accept that obesity is a huge problem, and that is the most up-to-date data that you have, then it is not anywhere near up to date enough. I believe that we should be doing more on obesity. We were involved in the safe food campaign before Christmas, which identified adults, but I know that there is a huge problem and that obese children turn into obese adults. We have an issue here, and it is getting worse. We know that the Department is planning and projecting future spend on obesity scales because so many of the population are obese, when a bit more spending on awareness to ensure that people have the proper diet and exercise would avoid that down the line. I just think that it is something that we know we could prevent.

Ms S Ramsey: I probably need to declare an interest.

The Chairperson: So do I.

Ms S Ramsey: A number of years ago the Committee held an inquiry into obesity. It might be an idea to find out where the recommendations that the Committee had put to the Department are sitting.

The Chairperson: OK, we will try to find that out. Julie, it is an example of the kind of thing that I was saying at the beginning — that this paper is all over the place, and the graph is not up to date enough for us to be able to identify where our main areas of concern should be.

Section 5.8 shows the waiting times for cancer treatment, and states that 98% of cancer patients should commence treatment within 31 days of the decision to treat. However, the chart shows that the rolling average is below the target for significant periods. Therefore the target was not met, yet this document states that it was "substantively met". This is one of those times where you ask was it met or was it not met? If it was substantively met, that means that it was not met. Some of us are new to this Committee, and may need more help to understand the figures, but it seems to me to be a difficult and complex issue that is made more complicated. Jim, you wanted to come back in. Are there any other views before I go back to Jim?

Mr Wells: I see a big cut in expenditure for Fermanagh that you announced when I was in the Chair. In relation to generic dispensing rates, the table in my papers is not very clear, but I am I correct in thinking that the Southern Trust is significantly ahead of the others in that field? From my document, I cannot tell the difference between the symbols for the Southern Trust and the Western Trust. Is the Southern Trust at the top of the generic average?

Ms Thompson: Yes. My understanding is that it is the southern LCG.

Mr Wells: So the Southern Trust is significantly ahead. For instance, at March 2011, some trusts were averaging 62%, but the Southern Trust was up at about 64%. It is quite good news that the percentage has gone from 43% to 62%. Can we put a figure on how much that has saved the Department?

Ms Thompson: As I said to Mr Dunne, the savings in pharmacy for 2011-12 are forecasted to be £30 million. I guess that you are asking about the duration. I do not have that to hand, but I can certainly get that for you so that you can see what that has translated to from 2009 through to March 2011.

Mr Wells: It is a 50% increase in generic usage. It would be interesting to know whether we could get all the trusts up to the level of the Southern Trust. I have to be careful, because I am in the Southern Trust area, but, in every table, that trust seems to be at the top of the pile. If it can do it, perhaps others can follow the lead. If you get everyone up to that level, there must be very significant savings to be achieved for next year.

Ms Thompson: You are quite right; we keep a very close eye on it. There is a need for everybody to improve but, equally, for those at the lower side of the table to improve further than others. I am certainly happy to come back to the Committee about what has been saved to date from that increase.

Mr Wells: There is nothing radically different between the people of Kilkeel or Crossmaglen and the people of Drumahoe and Castlederg. Clearly, there is low-hanging fruit that can be gathered, and you will need it next year, given the answer that you gave to my previous question.

This is perhaps not just as easy to answer: you said something quite remarkable, Christine, in your answer to Kieran's question about the fact that chart 9 at 5.4 should not be in the paper. I have never heard that stated before at a hearing. Who authorised its inclusion?

Ms Jendoubi: We were just —

Ms Thompson: I can answer that, if you do not mind. It came from work with the board around particular aspects and outcomes. I appreciate the issues that the Committee raised. This was never meant to be a full and comprehensive analysis of all our targets and where they are currently. It was pulled out, Jim, at a point in time, and it is being worked on from the board's perspective. If there are other tables that the Committee would find helpful, we are more than happy to look at that, but the document was never meant to be a full and comprehensive analysis of all the targets and where we are against them.

Mr Wells: Following on from what the Chair said, the document has all the appearance of having been pulled together by experts but not reviewed by an editor. In other words, there is obviously some good news in the report; things could have been so much worse. However, it might be worth asking someone with a journalistic flavour to run their eyes over the coherence and accuracy of it. It has all the signs of being a paper that was produced by a committee rather than an editor. There are quite a few wee typos, and tables have been left out. In future, some of that skill is needed. It may not be a high-powered medical skill; it is more an editorial skill.

Ms S Ramsey: They could build relationships with the 'The Irish News' at the same time.

The Chairperson: Before we let you go, Julie, this is a strategic resources framework 2011-12. We are eight and a half months into that financial year. You said that it was not a full and comprehensive analysis of that year. When will we get a full and comprehensive analysis of 2012-13 so that the Committee can consider it properly? It will be the Minister's first year of putting his stamp on it, given that he came in part of the way through the year. We need to see a full and comprehensive analysis. Coming here with anything less really is not good enough, so bear that in mind for the next time.

Ms Thompson: OK.

The Chairperson: Do you have any idea of when we will see that?

Ms Thompson: It starts with the commissioning plan direction, which, hopefully, you will discuss next week. A commissioning plan comes in after that as another key piece as we look for 2012-13. That type of more detailed analysis, which runs off the back of that work, tends to follow through in the summertime. I can certainly look at timelines and see how that can be addressed. As I said, that relies on those decisions being taken and the planning process being worked through. I can take back the information that the Committee is keen to see it as early as possible. However, the earliest that that will be available is the summer. We plan to make the commissioning plan available before the end of the financial year.

The Chairperson: The Committee does not meet during July and August. It would be helpful if we could get it earlier than that, so that we could look at some of the issues.

Ms Thompson: I can take that back. That would mean a significant shift in timelines, and I am not sure what we can do to move it on. However, I can certainly relay your concerns and see whether anything can be done earlier.

The Chairperson: OK. As there are no more questions, I would like to thank Julie, Peter and Christine.

Mr Wells: In case anyone thought I was being serious, there are not cuts planned for Fermanagh.

The Chairperson: What was that, Deputy Chair?

Mr Wells: I dropped in a line that cuts were announced for Fermanagh when I was chairing the meeting. That was a joke.

The Chairperson: OK. It is unusual for you to make one. *[Laughter.]*

Before you get up Julie, I understand that The Department of Finance and Personnel (DFP) is looking for savings delivery plans from each Department for 2011-15 and that only a few Departments have not produced those yet. When will the Department of Health put forward its plan?

Ms Thompson: I guess that brings me back to where I started the conversation. We are looking at the plans for 2012-13 at the moment. Hopefully, those should become clear in the next few weeks, and we should be able to put something out relatively soon. The future planning process for 2013-14 and 2014-15 will take us into May or June. That work is partly tied to the population plans that were discussed in 'Transforming Your Care'. Therefore, we intend to deal with 2011-12 and 2012-13 in the next few weeks, and the plans for 2013-14 and 2014-15 will follow in May or June, when the plans have been more appropriately developed.

The Chairperson: I think that most Departments have put in their savings delivery plans. Would population changes not impact on those Department also?

Ms Thompson: I did not mean population changes; rather, I meant the population plans that are part of 'Transforming Your Care' and that will be available in June. As discussed, those plans will shape how we implement that document and what it will mean. They need to be factored into the overall planning process, and it is our intention to do that over the next few months. However, work needs to continue to allow us to put something into the savings delivery plans.

Mr Durkan: I have a supplementary question that relates to your question, Chair. Will the Business Services Transformation Programme (BSTP) proposals be integral to the savings delivery plan?

Ms Thompson: The shared services proposals are absolutely part of the savings that we anticipate making over the next few years.

Mr Durkan: Julie was at a consultation event in Derry last night, and I am sure that that meeting was even worse than today's meeting for her.

The Chairperson: I heard that you were in good form.

Mr Durkan: The Committee has agreed to hear evidence on the consultation after it has been completed. However, having taken part in that event last night, I think that it might be more beneficial for the Committee to take part in the consultation process. I have serious concerns about the consultation. Those concerns might become more evident to the Committee during the consultation rather than afterwards.

The Chairperson: Our role is to ensure that the consultation process is done properly rather than to be stakeholders in it. That is why we wanted to wait until the consultation exercise has been completed and the summary of responses has come back. I am not sure.

Mr Brady: I was at one of the consultation events that was much more civil than the one in Derry. There are gaps. We asked questions about what might happen with voluntary retirement and redundancy and what the timelines are for that. The consultation will give a bit more information about what might happen in those areas by 31 March, which is the cut-off date for people to make decisions. However, they will be making decisions without knowing what they are going to decide. You could not give people figures and so on, so they do not know whether it will be worthwhile. It would seem more sensible to wait until after the deadline, when we will, presumably, have more information.

The Chairperson: The lack of information before 31 March was one of the areas that Mickey had identified to me. That deadline seemed to be a wee bit arbitrary. One of my concerns was about whether the 31 March deadline could be pushed back a bit if the Committee needed time to consider the summary of responses. That would give us the opportunity to scrutinise the process, and,

hopefully, there would be more information on which to base a decision. Mark, I am trying to ensure that we are doing what we are supposed to be doing. It could very easily get down to a constituency-level discussion, and, as a Committee, that is not what we are here to do.

Mr Durkan: There is a wider issue here that is the responsibility of the Department. Given the tight timelines and the 31 March deadline that has been set, there is a possibility that people may lose their jobs by the time the issue comes to us for consideration.

The Chairperson: It is coming to us for consideration in February, I understand. We will let Julie and Christine go, and we will have a discussion about it ourselves. Thank you very much for coming in; we will look forward to seeing you again.