Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Programme for Government Delivery Plans: DHSSPS Officials

25 June 2014

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Roy Beggs
Mrs Pam Cameron
Mr Samuel Gardiner
Mr Kieran McCarthy

Witnesses:

Ms Catherine Daly	Department of Health, Social Services and Public Safety
Mr Seán Holland	Department of Health, Social Services and Public Safety
Dr Liz Reaney	Department of Health, Social Services and Public Safety
Ms Julie Thompson	Department of Health, Social Services and Public Safety

The Chairperson: I welcome Julie Thompson, deputy secretary, resources and performance management in the Department; Ms Catherine Daly, deputy secretary, healthcare policy group; Mr Seán Holland, deputy secretary of the Department; and Dr Liz Reaney, acting deputy Chief Medical Officer in the Department. You are very welcome and are well familiar with the procedures, so if you give a 10-minute presentation, then we will open it up to questions.

Ms Julie Thompson (Department of Health, Social Services and Public Safety): Thank you, Chair, and thank you for the invitation to appear before the Committee to discuss progress against Programme for Government commitments since our last appearance on the issue, which was in September last year. Catherine will lead on responses to questions about commitments 44, 79 and 80, Dr Liz Reaney will lead on commitments 22 and 45, and Seán will lead on any questions to do with commitment 61.

The Department leads on six commitments, each of which has three milestones to be achieved, one per year from 2012-13 to 2014-15. Those are all set out in the briefing pack provided to the Committee. Two relate to the public health agenda and obesity. One is focused on long-term chronic conditions, one on improving safeguarding outcomes for vulnerable children and adults, one on improving access to treatments and new services, and one on reforming the delivery of health and social care services to improve the quality of patient care.

In line with the central framework and guidance, the Department has a Programme for Government delivery plan in place for each of those commitments, the latest versions of which were sent to the Committee in advance of today's session. We send those to you at the request of the Committee on a quarterly basis so that you can see how those are moving ahead. Each delivery plan is owned by a senior responsible officer in the Department. They are living documents that can be updated

throughout the process. Currently we have been consistent with our milestones and the commitments.

The latest OFMDFM-approved progress reports are from March 2014. That is the position that we want to discuss with the Committee today. The position, as reported and approved by OFMDFM, is that four commitments — 44, 45, 79 and 80 — were rated green, ie fully on track for delivery, and two commitments — 22 and 61 — were rated green/amber, broadly on track for achievement with easily redeemable deviations. The Department remains confident that all the commitments that are reported as green/amber will be back on track and will achieve milestone three by the end of March 2015.

The Department continues to monitor the progress of all of its commitments and milestones through its own normal business planning, monitoring and reporting processes. There are regular reports to the departmental board and the Minister. Delivery of those commitments and milestones also requires action by a number of our arm's-length bodies, most notably the Health and Social Care Board (HSCB), the Public Health Agency (PHA) and the trusts. We work closely with those bodies to ensure that they are in a position to deliver on the Programme for Government.

As you know, formal progress against the delivery of Programme for Government commitments is also monitored by a central Programme for Government team, which comprises OFMDFM staff supported by colleagues in DFP supply throughout the Programme for Government period. We are more than willing to take any questions that the Committee may have.

The Chairperson: Thank you for that. I am not sure who you said was dealing with commitment 22.

Dr Liz Reaney (Department of Health, Social Services and Public Safety): I will deal with that one, thank you.

The Chairperson: One of the issues is the investment of the additional £10 million in public health.

Dr Reaney: Yes, that is right.

The Chairperson: Has that money been invested?

Dr Reaney: Yes, it has. In fact, it has been exceeded. The baseline, in terms of the PHA budget that we are starting from, was £77·2 million in 2011-12. So, an additional £10 million would bring that up to £87·2 million. Last year and this year, it has been well over £90 million, so that has been exceeded. The actual figure for funding from the Department in 2013-14 was £92·6 million, and for 2014-15 the initial allocation is already £91 million and there is additional money to come. So it has already exceeded the £87·2 million that would be the additional £10 million.

The Chairperson: What percentage of the overall budget goes to public health? Do we have a figure?

Dr Reaney: PHA spend as a percentage of the total Health and Social Care budget has risen from 1·77% in 2011-12 to 1·95% for 2014-15. As I said, that will increase.

The Chairperson: The reason I ask is that one of the issues when the Committee was doing work on health inequalities was the recommendation from the World Health Organization (WHO) that your spend on prevention and early intervention should be in and around 6% of the overall budget. We do not seem to be in line with that.

Dr Reaney: I am aware of that report and the figure of 6%. We seek all the time to increase the percentage of spend that goes to public health and prevention. The issue here is that a percentage depends on what goes into the numerator and what goes into the denominator, so we need to make sure that we are comparing like with like.

In terms of the WHO definition that is used — the Organisation for Economic Co-operation and Development (OECD) definition — the things that are included in the numerator — the top figure — is somewhat wider than what we include for PHA spend. There is also an issue with what is included in the denominator: whether it is a percentage of health spend or Health and Social Care spend. Our officials are looking at the OECD definition to see, if we used that and applied it to the spend in Northern Ireland, what the percentage would show, so that we can compare like with like. We know

that, in terms of the milestone, we have increased the spend by over £10 million. We have increased the percentage to around 2%, but only after using the different methodology would we be able to compare that figure directly with the WHO figure. That work is complex in terms of what does and does not get included. We want to make sure that we come up with a robust figure that compares with the OECD figures. We hope to have that work completed in the autumn and to share it with the Committee at that stage.

The Chairperson: The other issue was in relation to commitment 80, "Reconfigure, Reform and Modernise the delivery of Health and Social Care services to improve the quality of patient care". One of the milestones was:

> *"Secure a shift from hospital based services to community based services together with an appropriate shift in the share of funding in line with the recommendations of Transforming Your Care".*

I am assuming that that funding that we refer to is the shift of the £83 million.

Dr Reaney: Yes, that is right.

The Chairperson: Can you maybe confirm how much of that £83 million has been shifted?

Ms Catherine Daly (Department of Health, Social Services and Public Safety): That milestone relates to 2014-15, so we do not have an exact measure of that at this point in time. There are a number of actions already put in place by the board to move towards that shift. We do not have a full quantification of what will be secured by the end of 2014-15 because, as we told the Committee last week, we are bidding as part of the June monitoring process for some elements of funding in relation to the transitional funding for Transforming Your Care (TYC). That could have an impact on the shift, but the target is £83 million and that is what we are working towards in 2014-15.

Ms Thompson: We have just closed off the 2013-14 financial year, and we will be getting figure work on how much we have achieved to date. We just do not have it right here today.

The Chairperson: Do we have any indication at all, given that this — again, I do not need to rehearse this — is an evolving process, but one that has been in progress for a number of years now in terms of TYC? How much has actually been shifted? How much was shifted last year, for example? If we do not know the figure for 2014-15, do we know the 2012-13 figure?

Ms Daly: We do not have that figure with us, but the board is preparing figures for us in terms of the broad indication of the expected movement by 2014-15.

Ms Thompson: We can get the Committee the 2012-13 figure. We do have that figure; we just do not have it here. When we close down the 2013-14 process, we will have that figure with you as well. We can certainly get you the 2012-13 figure. That will be known.

The Chairperson: I would appreciate that, but I will reiterate that in terms of our scrutiny and participation in the Programme for Government delivery, this is a piece of work that we will do. It is not something new. Therefore, I assume or suggest that the Department should be bringing those figures to us. We should not have to seek them. I would appreciate it if that figure was shared with us as soon as is practicably possible.

Another issue — I think you are dealing with this, Seán — is commitment 61, "Introduce a package of measures aimed at improving safeguarding outcomes for children and vulnerable adults".

Mr Seán Holland (Department of Health, Social Services and Public Safety): Yes.

The Chairperson: Some of us attended the event today, and I am sure you will be aware of it, about the report from the Older People's Commissioner calling for safeguarding legislation for adults. Suffice to say, some of the stories were quite stark. It was clear that experts were saying that safeguarding legislation would not resolve all our issues, but that the incidents that are happening, particularly to vulnerable adults, would not happen in child protection or in cases dealing with children or young people. I am aware, because the Minister spoke at the event, that there is a current review

of safeguarding policy. Is there any indication or sense that that policy will be underpinned by legislation?

Mr Holland: We have been working closely with the Commissioner for Older People on that issue. We have agreed that in the process of consulting on the new policy, we will also consult on potential new legislation. So it is definitely something that there is a possibility of us pursuing, and we will explore it through a consultation exercise in line with the policy. I would just add a note of caution: there are useful parallels to be drawn between safeguarding children and safeguarding vulnerable adults, but there are also significant differences. The nature of childhood is, by definition, a state where we expect adults to intervene and make decisions for children and to protect them. While vulnerable adults need protection, we also have to balance that with their autonomy and their right to make choices which are not always the choices that we would make for them. I am not sure whether that is relevant to the specific point that you are making, but it is just a note of caution that you cannot always draw an exact parallel between children and adult safeguarding.

The Chairperson: No, and I think that they are distinct pieces of work, but nonetheless I do not think that that gives us a profile over one as to the other. When you say that you are liaising with the Older People's Commissioner, is there a timeline around recommendations for both the policy and/or a decision on legislation? Is there any sense of that? That is the first question, around the timeline. Secondly, it was apparent from listening to the expert who was there — I cannot remember the professor's name now, but he was from Wales — that the models elsewhere have has positives and negatives, but there has been clear learning from some of them. Is the Department exploring models from elsewhere of how the legislation has been worked up and implemented?

Mr Holland: To answer your first question, we are planning to consult on policy in the autumn of this year with a view to final policy being published next year. That will be the timeline when we will also be considering whether legislation is appropriate. In terms of lessons from elsewhere, yes, very much so. Part of the development of the paper for consultation has involved us looking at developments in England, Wales, Scotland and the Republic of Ireland. There are variations that each of those countries have taken. Some things have clearly worked well; with others, issues have arisen. One of the common difficulties that colleagues in England, Scotland and Wales have referenced to us — we have experienced some of this difficulty — is inappropriate use of safeguarding procedures for issues that could otherwise be dealt with by existing policies and procedures. As a result, the safeguarding mechanism is becoming bogged down by a huge volume of referrals. That is one of the things that we are particularly looking at. One of the worst things that could happen is that the importance of adult safeguarding becomes devalued because people think: "That is just a bureaucratic process; it is overloaded with inappropriate referrals." So that is one of the things for which we are certainly looking to the other countries and considering their experience in how we develop our policy.

The Chairperson: Just finally, it was very apparent today that, in particular, the case of the situation in England was given, where the legislation is considered to be minimalist. Wales possibly, or Scotland —

Mr Holland: Scotland would be seen as —

The Chairperson: Scotland was seen to be ahead of that. I think that there is learning there that, hopefully, the Department is taking on board. One specific issue in relation to adult safeguarding is that of whistle-blowers. Increasingly, there is the concern that somebody comes forward to do what is right, and we should be supporting them in their duty and responsibility, and quite often the perception is that the whistle-blower is the person who has to jump through the hurdles and, quite often, they end up feeling more vulnerable than people in the story that they are taking forward or reporting on. In relation to this Programme for Government commitment on safeguarding, what are we doing to protect or support whistle-blowers?

Mr Holland: Whistle-blowing is not featuring specifically within this Programme for Government commitment. However, as you will be aware, the Minister has, in evidence to this Committee, given a very strong commitment to supporting whistle-blowers and has issued public statements, on more than one occasion, encouraging people to be whistle-blowers if they feel the need to do so. He also stated that they would be supported — and need to be supported — both by the Department, the HSCB and employing organisations such as trusts. Catherine, I do not know whether you have anything to add from a personnel perspective?

Ms Daly: I reiterate the point that the Minister has been very public in his view on the importance of the whole whistle-blowing policy and the need to ensure that whistle-blowers are properly protected. It is a key issue for the Department in working with all of the HSC bodies.

Mr Holland: One feature that we are taking forward and have taken forward specifically in relation to safeguarding is the training of staff to understand what safeguarding is, what vulnerable adults are and what abuse is. I think that is one of the key things. People need to recognise that a situation is unacceptable to realise that they might want to be a whistle-blower, although, in the majority of instances, when staff see something that concerns them, they are able to address it without becoming a whistle-blower as such. Whistle-blowing is where you feel that your organisation is not taking a concern seriously. We are investigating hundreds of vulnerable adult safeguarding investigations where staff have raised concerns without having to become whistle-blowers. We are also dealing with whistle-blowing incidents, but, in the majority of cases, we find that, when staff are given good training, they report things to their colleagues and to their line manager and organisations are invoking safeguarding vulnerable adult processes.

The Chairperson: I do not want to get bogged down in the detail of that, but, whilst I accept that whistle-blowing might not be directly impacting on this Programme for Government target, it was clearly in the room today around developing safeguarding legislation as a key issue going forward. I also respectfully say to you that the issue of training was raised today by the Association of Social Workers in particular, which said that there are safeguarding procedures that are taking place down a telephone, and that that simply would not happen with child protection but that it is happening with adult safeguarding. I suggest, Seán, without opening up the entire debate, that you reflect on that as well and that, as the policy evolves and the thinking around legislation evolves, this Committee is kept informed of that.

Mr Holland: Of course, as we go to consultation, as is always the case, we will be engaging with the Committee. If the Committee wishes, we can supply you with some information about the training and public awareness initiatives that have already taken place in relation to adult safeguarding.

The Chairperson: I think that it might be better, for the purposes of today, to reflect with the Association of Social Workers as opposed to the Committee. It made the comments.

Mr McCarthy: Thanks for your presentation. I am looking through this document, and correct me if I am wrong. It states:

"the Mental Capacity Legislation will not be passed within the current mandate of the Assembly."

Mr Holland: No, that is not correct. Our ambition is to bring forward the mental capacity legislation within the current mandate. The last time we were here, we discussed this, and I was taken to task for the fact that the actual chronological date had slipped, but I said that the commitment was to date within the mandate of the Assembly. That still is our plan. I apologise if there is —

Mr McCarthy: I just picked it up this minute while I was listening to you.

Mr Holland: I apologise if there is —

The Chairperson: Kieran, for clarification, that might be the risk register that you are referring —

Mr McCarthy: Oh, yes it is.

Mr Holland: Yes, we have identified the risk that it would not pass during this Assembly, and we are trying to manage that risk. Currently, we are in consultation stage. Committee member Wells is not here, but, if I recall, he challenged me to a wager on whether or not we would get it through the Executive in time, and indeed we did.

Mr McCarthy: That clarifies that, because I know that you made a commitment, and we all want to see that before the Assembly mandate runs out.

What evidence can you show for a reallocation of resources to invest in mental health funding? You will be aware that the gap in mental health funding between here and the rest of the UK is quite significant and that we are trying to shorten that gap.

Mr Holland: I do not have the figures with me, but there has been a programme of investment flowing from the Bamford review a number of years ago, and different investments have been made on the back of that. I will be absolutely open in saying that the levels of investment never reached the ambitions that we had for that programme. We can supply for you detailed figures for the investment since the publication of Bamford.

Mr McCarthy: That would be very useful, because, as you know, mental health has always been the Cinderella of the health service, and we are trying to close that gap. If there is any information that you can give us, it will be very useful.

Mr Holland: We will do, certainly.

Mr Beggs: I looked through the Programme for Government commitments, and some of them are just about spending money, as opposed to what the outcome is going to be. Was that thought about before they were committed to? Spend £10 million on public health, tick the box and you have your commitment. There is £2·8 million this year on obesity. It is not about having health improvements and reducing the number of people presenting with obesity to hospitals.

Ms Thompson: I appreciate the essence of the question. They were set up that way and agreed by the Executive, I guess. Therefore, we have been monitoring against the way they have been specified. I understand completely the importance of, "What do you actually get out of that?" I am sure that Dr Reaney can give you a flavour of some of the initiatives that have been put in place on both public health and obesity.

Dr Reaney: The two big things in obesity are to level the amount of physical activity and make sure that people are eating appropriate quantities of healthy food. However, we need to take a wider approach than that and look throughout life. I will pick out just a few examples.

In 2012-13, some of the programmes or pieces of work taken forward by funding were on breastfeeding services, a public information campaign, food poverty initiatives, outdoor gyms, physical activity referral programmes and research into gestational diabetes.

In the following year, the PHA brought in a pilot weight-management programme for pregnant women who are obese. That is a risk for the women and the babies. There was work with other Departments on active travel for schools, and allotment sites. This year, there is further developing the active travel in schools; there is a Belfast active travel pilot. There is work on food in schools to encourage healthy diets from an early age and increase fruit and vegetable consumption. There is improved coordination of various activity referral programmes and further work on the breastfeeding strategy.

There are a wide range of programmes trying to address the entirety of the factors that affect obesity. Obesity — that is, being overweight or obese — is the seventh most significant factor in mortality and the eighth most significant factor in disease, and it can actually decrease life expectancy by up to nine years. In addition, there is a considerable financial impact at a population level. In 2009, work was done that estimated that obesity cost the population £400 million. Of that, 25% was in direct healthcare costs and the rest was in indirect costs, so it is important that we tackle it in a broad manner.

Mr Beggs: You are talking about a lot of worthwhile progress and programmes, no doubt, but are you getting on top of obesity, for instance? Are the programmes working?

Dr Reaney: That will be reflected in whether we see the rate of increase in levels of obesity being stabilised and then, ultimately, decreased. The targets for the strategy are to decrease the rate of obesity and being overweight. Programmes like this will take some time. It cannot be resolved by just one-year, two-year or even three-year funding. There is a major change at so many different levels, and it is being closely monitored. BMI measurements are carried out in schools and so on. There is always an evaluation element built into the programmes to make sure that the funding we invest is used in the most appropriate, effective and efficient way.

Mr Beggs: Commitments 22 and 61 are marked amber. Why should there be any difficulties with them?

Dr Reaney: Had you got the papers a week later, commitment 22 would not have been amber. I am pleased to say that, yesterday, the Minister made a statement to the Assembly on Making Life Better, which is the new public health framework and was the one aspect of commitment 22 that was outstanding. The three milestones for 2012-13 were the new policy direction, which is Making Life Better. You will remember that publication was delayed to take into account the work that the Committee had done on health inequalities and other evidence that had come forward in the meantime. Now that that has come through the process, been launched and is on the departmental website, that milestone has been achieved, along with the bowel cancer screening milestone and the additional £10 million on public health spending, which we mentioned at the start of the session.

Mr Beggs: Is milestone 3 of commitment 61:

"Develop an updated inter-departmental Child Safeguarding Policy Framework"

amber?

Mr Holland: It is. There are different reasons for the delay on commitment 61. We had some issues when key staff moved on, and there was a period when we were waiting for a new member of staff to get up to speed.

We also had issues with some new initiatives, particularly those on sexual and domestic violence. In negotiations on the shape of the new initiative — I am thinking in particular about the independent domestic violence advisers (IDVAs) and independent sexual violence advisers (ISVAs) — stakeholders have been engaging with us on what the job description should look like and how the advisers should be deployed. That has turned out to be a more complex process than we had envisaged.

We also had some additional unplanned but very important work. Indeed, the Chair's question referenced some of it earlier. We engaged significantly with the Commissioner for Older People on her report, recognising that that work would be of value to us when we publish our policy. We have also had some additional work — relevant but additional — on Lord Morrow's private Member's Bill on trafficking. We had to make sure that we were taking into account those developments in the development of our policy.

Mr Beggs: I hope that you will be able to achieve your milestone. It is important for children in our community.

Mr Holland: It is important for children and adults. It is at green/amber, which means that we anticipate getting back on schedule.

Mr Beggs: Finally, if I may, Madam Chair, in commitment 80, milestone 2 for last year was that the number of excess bed days would be reduced by 10%, compared with the figure for 2011-12. What percentage did you achieve?

Ms Daly: We said that the percentage reduction would be at least 10%, and we exceeded that. The 10% against the 2011-12 baseline was just over 20,000 excess bed days. The latest figure for March 2014 is just over 19,000, which is below the required level and so exceeds the target. It has been lower than that throughout the period. There are peaks and troughs. I am sorry — I said that 19,000 was the figure for March 2014, but it is, in fact, the figure for December 2013. There is a time lag in the coding and measurement of the figures, so we do not have the figures right up to March 2014. However, on the basis of the information that we have, the target has been met and exceeded throughout the period, and our expectation is that the figure for March 2014 will show that the target has been exceeded.

Ms Thompson: Those are the monthly figures: 20,000 is the target figure per month, and 19,000 is the figure achieved.

Mr Beggs: I hope that the outcome of 19,000 was the result of a lot of activity and that patients are not being moved at the last minute to achieve that goal. How do you ensure that patient care is not endangered because of last-minute moves to achieve goals or target figures?

Ms Daly: That is an important point. A whole range of measures is in place to secure that reduction in excess bed days: it is about patient flows and management services in the community. In each, we look for services to be delivered safely and effectively in accordance with the proper standards and targets.

Throughout the whole HSC system, there are measures of control to ensure that actions will not be taken to achieve the target; they will be taken to ensure better care. The Minister has always been very strong on that. There is a whole range of measures, so it is not possible to say, "Here is one set of measures that addresses that particular commitment or milestone". It is made up of a whole range of measures across the service.

Mr Beggs: I am looking at the various Programme for Government commitments. It is a pity that they do not include waiting times at A&E of four hours or more and elective care waiting times — some of the really important things.

Ms Daly: In constructing the commitments and milestones, we try to identify what is meaningful in the whole context. You will be aware that, in the commissioning plan direction, emergency departments and waiting times are key targets for the Minister every year. In the delivery plan, one of the indicators of the effectiveness of delivery is ED waiting times, so we look at that as one of the measures that ensures its delivery.

Mrs Cameron: Roy touched on what I wanted to ask about commitment 61, in particular, domestic and sexual violence issues. I welcome the fact that the joint domestic and sexual violence strategy has been issued for consultation and will, hopefully, be published and launched later in 2014. We know that the sexual assault referral centre (SARC) is up and running, which is really good news. I wanted to ask about the commitment being green/amber, which means that it is broadly on track: is there a delay? I hope that any delay is because of the work of voluntary agencies and so on to ensure that the Department has done this right as opposed to just ticking a box, especially in relation to the ISVAs and IDVAs and ensuring that the roles are properly defined.

Mr Holland: Absolutely. Of 68 responses to the consultation, 13 were from key partner organisations that asked for further time to respond, so that added to the time frame. Even when they responded, because they had so much to say, some did not follow the consultation format, but we wanted to make sure that we captured what they were saying to us. That did cause some delay. A significant proportion of that was specifically on the role of the sexual violence and domestic violence advisers and making sure that they would not duplicate existing roles but would add value and fill gaps in current provision.

Mrs Cameron: I am very glad that it is a PFG commitment. It is, I think, vital.

The Chairperson: You talked about public health and the announcement of the Making Life Better strategy. As a matter of accuracy, because you said that you were reflecting on the Committee's work on health inequalities, we submitted that report to you in January 2013. We will take credit for some things, but we do not think that we necessarily delayed the announcement of Making Life Better.

One issue is health inequalities. Whilst I think that the strategy is a step in the right direction, we are, ultimately, talking about a whole-system approach. How do we use that approach to target the inequalities?

Dr Reaney: First, I apologise if I created the impression that the Committee was at fault for delaying the strategy; that was not my intention at all. It was an important report that had to be taken into consideration along with a variety of other work. A strategy such as this, by its very nature, gets a lot of responses and interest from a very wide range of people. You are correct in saying that it is a whole-system approach and that that is very much what is needed. Improving people's health in general, and reducing inequalities in particular, are certainly not the preserve of the Department of Health alone. Working with all the other Departments and voluntary organisations, the PHA and the HSC, will be required to take that forward.

The Chairperson: I asked my next question in the House after the ministerial statement. The Minister's statement reflects almost a one-size-fits-all approach to health inequalities, although a concept of proportionate universalism is built in. We know that health inequalities are stark between, to put it bluntly, those who have and those who have not, so how will a system that takes account of accessibility for all sections of society address the inequalities?

Dr Reaney: As you say, there are two approaches. The universal approach is to try to improve everybody's health. People who are more disadvantaged or have greater inequalities will need additional help to try to narrow that gap between the most disadvantaged and those who are least disadvantaged. There is not a one-size-fits-all approach. A lot of work is required at local level with communities who know what is needed for their locality. Important work needs to be done with the PHA, the board and, in particular, with local government because of changes occurring there and the need for community planning. Such work is important to ensure that it is not just a blanket approach but is tailored to meet the specific needs of local communities.

We have to try to make sure that the resources are used in the most effective and efficient way to have the biggest impact. Working with local communities and knowing the needs of communities or vulnerable groups enables work to be targeted there. So we are not starting from a blank sheet; a lot of excellent work is going on and has been for many years, following on from the Investing for Health strategy that dates back to 2002. It is a matter of trying to make sure that we build on that. It is time, I suppose, to have a bit of a refresh just to make sure that we set that strategic direction. We are pleased that the new framework for doing that, refocusing efforts and making sure that we are able to move this forward, has been published.

The Chairperson: I suggest that we all know where the health inequalities are. We do not necessarily need much more work on that, whether with local authorities, trusts or anybody else. We know the geographical locations, and it is clear that to redress the patterns and change outcomes, we need to do something very different, which is ultimately about targeting, monitoring and evaluating. I suggest that you come back to us in writing about how the whole-system approach versus targeting will be pursued. The risk is that we miss some of the harsh realities of health inequalities if we take a one-size-fits-all approach.

Ms Daly: I will pick up on and add to that. The Minister sets out priorities for the HSC and the commissioning plan direction, to which are scheduled specific targets. The commissioning plan direction sets out the Minister's direction to the Health and Social Care commissioners: how services are to be commissioned, taking account of the strategic issues and strategies for the Department, and that will include this strategy. The strategy is encompassed in the planning work for the commissioners and will be reflected in the commissioning plan direction. That is one key area in which the Minister will communicate that requirement.

The Chairperson: I do not want to get into the minute detail, but this is hugely important, so I am specifically asking for correspondence from you as the Making Life Better strategy moves on. We want to know about accessibility to public health generally and how that will be targeted. That is so that we can start to get a sense of how that target will eradicate inequalities. It would be useful to get and continue to receive that communication.

Finally, I wanted to raise Programme for Government commitment 79, which is to:

"improve patient and client outcomes and access to new treatments and services".

It is rated as green and fully on track for delivery. It is about enhancing access to life-enhancing drugs for conditions such as cancer. There is a list of conditions in the commitment, but it is really about cancer. I am mindful of the very public debate on this and of the inequality, so how can you rate that as green and fully on track?

Ms Daly: We are on track based on what was required under that specific milestone. The milestone for 2013-14 was specifically on the rolling out of the Family Nurse Partnership, and there is a whole combination of things right across the three milestones for that commitment. On the specific issue of cancer drugs, the Health and Social Care Board and the commissioning bodies in England follow the National Institute for Health and Care Excellence (NICE) guidance on the drugs that are available. For drugs available under the cancer fund in England, in Northern Ireland, those that are approved by NICE are available either on a recurrent funding basis or on a cost-per-case basis. In addition, for some drugs that are not approved and are of high cost, there is the process of the individual funding

requirement (IFR), whereby a clinician can put forward to the Health and Social Care Board a request for specific funding for that drug for an individual. So there is not a significant difference between the drugs available and accessible in Northern Ireland and those available and accessible in England, but the Minister has asked that we evaluate the individual funding requirement process to see how it compares with other areas.

The Chairperson: I want to be clear on that: you are saying that milestone 1 over 2012-13, which was to enhance access to life-enhancing drugs for conditions such as cancer, is green and fully on track, but it is not.

Ms Daly: For that period, expenditure on enhancing access to drugs went up from £61 million in 2010-11 to £90 million in 2013-14. Within that, the expenditure on cancer drugs went from £21 million to just over £26·5 million, an increase of just over £5·4 million. So there was increased expenditure in line with what the commitment required.

The Chairperson: There is increased expenditure, but there still is very clear inequality of accessibility. I am questioning the accuracy of saying that this is fully on track when we know that there are 38 cancer drugs available in England, Scotland and Wales that cannot be accessed here. So how can we say that we are on target?

Ms Daly: I will quote from my briefing on the 38 cancer drugs:

> *"It has been widely reported in the media that there are currently 38 cancer drugs available in the cancer drugs fund in England, which patients in Northern Ireland cannot access. The position is that all licensed drugs for treatment of cancer can be made available to patients in Northern Ireland, either as drugs that are routinely commissioned"*

— that is the recurrent funding that I was talking about —

> *"or drugs that are provided on a one-off basis on the basis of a patient's clinical exception".*

The Chairperson: The exceptionality clause is also an issue. Increasingly, that is a barrier, not only to the patient who has to prove that their cancer is biologically exceptional but to GPs, who, quite often, do not apply to the system and say that very clearly. That hurdle should be removed. I go back to my point on seeing progress on delivery. We are being told that something is green and fully on track, yet we know that accessibility is not on track.

Ms Daly: The milestone has been delivered according to how it was articulated. Perhaps that milestone does not articulate the specific issue that you are highlighting. The evaluation of the IFR process requested by the Minister will look at the process, the accessibility, the numbers in Northern Ireland and at how effectively it works. It will also look at good practice in other areas.

The Chairperson: I take issue with the fact that it is green. I hear you talking about enhancing access and maybe there has been more spend, but is that more spend on the same programmes and treatments?

Ms Daly: No, not necessarily, because it takes account of, for example, specific spend on drugs under the IFR process. I have details of the expenditure on specific drugs.

The Chairperson: You detailed the increase in expenditure. I am asking whether it is just more of the same.

Ms Daly: No, it is not. This milestone does not relate to cancer drugs alone; they are one element of it. It also relates to anti-TNFs for rheumatoid arthritis, psoriasis and Crohn's disease and drugs for multiple sclerosis, wet age-related macular degeneration (AMD), retinal vein occlusion and diabetic macular edema. It is about enhancing access to drugs across a range of areas in order to enhance people's quality of life and outcomes. It is not explicitly or exclusively about cancer, although cancer is an element of it.

The Chairperson: I accept that it is bigger than that, but I still take issue with its being rated fully on track.

Mr Beggs: In justifying the green rating, you simply used the budget, which went from about £20 million to £26 million. You say that people have enhanced access and an increased likelihood of being awarded the drugs, but has there been, for instance, a significant increase in patients presenting? Although your budget has increased by £5 million or £6 million, that does not necessarily justify your saying that there is increased access, so how can you reassure us of that?

Ms Thompson: Access is also about the waiting times for access to drugs. We know that the waiting times have been reducing for that range of drugs.

Mr Beggs: My question was whether more patients are presenting for that increased number of drugs. Is there increased access or not? From what your are presenting to us, I do not know.

Ms Daly: I understand. There is probably more detailed information that we could provide to the Committee on the number of people who have accessed the drugs, exactly how we measured that against the milestone and how that was crafted.

Ms Thompson: New drugs come online every year. When we talk to the Committee about the financial position, one of our pressures relates to the additional drugs coming online through the NICE processes. Patients are constantly getting access to those. The waiting times for drugs are reducing, so a lot of work has gone into that.

The significant increase in spend was over a short period but it is continually moving. There will always be new drugs coming online and on stream. The IFR process is part of access to such drugs when they are unapproved, as opposed to those coming online through NICE processes. There is a lot of focus on ensuring that people get the NICE-approved drugs as they need them, which has a significant impact on spend in the system.

Mr Beggs: The impression that I got from clinicians is that IFR is not giving access; it is limiting access to many.

Ms Daly: I hear what you are saying. The Minister has asked that we carry out an evaluation, but our indications are that about 98% of referred IFRs are approved.

Mr Beggs: Do you accept that many clinicians have stopped using the IFR because they know that they will be turned down because the case is not exceptional?

Ms Daly: We will carry out the evaluation that the Minister requested, but I understand the points that you are making.

The Chairperson: Finally, I would like clarification on a similar issue. There is much debate currently about the pharmaceutical price regulation scheme (PPRS). Has money come back into the system here?

Ms Thompson: The level of increase in the pharmacy budget is less than it would otherwise have been. In 2013-14, it was £2·8 million. That is, effectively, less growth. The growth would have been at a higher level to the tune of £2·8 million. So the pharmacy budget has grown by less than would otherwise have been the case. That is, I guess, the best way to describe that.

The Chairperson: You can come back to us in writing on this: there is an indication, particularly from the cancer research unit and the Pharmaceutical Association, that the new regulations came in only on 1 January 2014. So we are not talking about previous years. The scheme signed off by the industry and the Department of Health in Westminster has been in place only since January. My question is this: since January, has there been a return? If so, how much, and has it been targeted at the accessibility of treatments and drugs?

Ms Thompson: You are absolutely right. A new scheme came on in 1 January 2014, and it limited the increase in the pharmacy budget, which increases on an ongoing basis as new drugs become available and to take account of price inflation. The scheme reduces that level of increase. So when

we are talking to the Committee about the overall financial position, the pharmacy budget and the pressure within it moderated or reduced as the PPRS came into play. It impacts on the level of growth in the pharmacy budget and means that it is at a lower level of growth than would otherwise be the case, but it is still increasing as we look ahead.

The Chairperson: So why do organisations say that there is a return into the system?

Ms Thompson: It is a lower level of growth.

The Chairperson: How much of a difference are you talking about?

Ms Thompson: My understanding is, when the number is clarified, that it is £2·8 million from the old scheme in 2013-14. I am not sure of the number for 2014-15. I would need to come back to the Committee on that.

The Chairperson: Can you come back to the Committee on that? Was the £2·8 million for 2013-14 just redirected across the system?

Ms Thompson: No, it impacts on the pharmacy budget, so our spend was less than it would otherwise have been, but there is still a pressure in that overall budget. It means that the increase in that budget is less than it would otherwise be. That impacts on the overall financial position as you look at it.

The Chairperson: Will you come back to us with clarification as soon as possible of the implications of the new contract that was signed off and came into place in January?

Ms Thompson: Yes.

The Chairperson: Thank you. We have raised a number of issues and look forward to your written responses.