Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Programme for Government Delivery Plans: DHSSPS Briefing

25 September 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen

Witnesses:

Ms Catherine Daly	Department of Health, Social Services and Public Safety
Mr Sean Holland	Department of Health, Social Services and Public Safety
Dr Elizabeth Mitchell	Department of Health, Social Services and Public Safety
Ms Julie Thompson	Department of Health, Social Services and Public Safety

The Chairperson: Catherine and Julie have stayed for this session and are joined by Sean and Elizabeth. I will hand over to you for the 10-minute presentation, after which we will open it up for questions.

Ms Julie Thompson (Department of Health, Social Services and Public Safety): Thank you for the invitation to appear before the Committee to discuss the progress being made in the Department's 2011-15 Programme for Government (PFG) commitments since our last appearance before the Committee on this subject, which was in October 2012.

The Department of Health, Social Services and Public Safety (DHSSPS) leads on six commitments, each of which has three milestones to be achieved: one a year from 2012-13 through to 2014-15. The commitments and milestones are set out in annex A of the briefing paper. 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 patient care.

In line with the central framework and guidance, the Department has a PFG delivery plan in place for each commitment, the latest versions of which we shared with the Committee in advance of today's evidence session. Each delivery plan is owned by a senior responsible officer (SRO) in the Department. The delivery plans are living documents, which are updated throughout the process, although there is currently no intention to amend the milestones or commitments.

The latest progress reports that were approved by the Office of the First Minister and deputy First Minister (OFMDFM) were for June 2013. The position as reported and approved by OFMDFM is that three commitments — 45, 79 and 80 — were rated green and are fully on track for delivery. Three commitments — 22, 44 and 61 — were rated as green/amber, ie they are broadly on track for achievement with easily redeemable deviations. The Department remains confident that all the commitments reported as green/amber will be back on track and will achieve milestone 2 by the end of this year.

Regarding issues raised by the Committee, Catherine will deal with long-term conditions, improving access to treatments and new services, and the reform of Health and Social Care. Liz will deal with the two commitments on public health and obesity, and Sean will deal with the commitment around vulnerable children and adults.

The Department continues to monitor the progress of all our commitments and milestones through our normal business planning, monitoring and reporting processes. That includes regular reports to the departmental board and to the Minister. Delivery of these commitments and milestones also requires actions by a number of arm's-length bodies. We work closely with those bodies to ensure that they are in a position to deliver on the Programme for Government. Formal progress against the delivery of the commitments is also monitored through OFMDFM throughout the PFG period. We are more than happy to take any comments or questions that you have on the issues raised in the paper.

The Chairperson: OK. We will just wait for questions to flow in. Commitment 61 is about safeguarding outcomes for children and vulnerable people. This question is probably to Sean. For year 3, the milestone is to develop an updated interdepartmental child safeguarding policy framework. What progress has there been on that? What is it hoped that the updated framework will achieve? What is your view on how effective the current interdepartmental child safety policy framework is?

Mr Sean Holland (Department of Health, Social Services and Public Safety): The current policy is based on the document 'Co-operating to Safeguard Children' and has been in place since 2003. Since then, there have been a number of developments in our understanding of how best to protect children across the UK. In particular, I refer the Committee to the events flowing from the death of Peter Connelly, which led to two significant changes that influenced us to decide to include this as a milestone. One was the establishment of the reform and modernisation board for social work in England, and the other was the work of Professor Eileen Munro from the London School of Economics. Both those initiatives highlighted that one of the difficulties with procedure, policy and guidelines around child protection was that it had become layer upon layer. There have been numerous inquiries into situations where things have gone wrong in child protection, such as the Victoria Climbié inquiry, which, I am sure, members will recall. The response to that was to issue lots of recommendations. It was felt that, as a result, protecting children had become excessively bureaucratised, and there was a squeezing out of the scope for individual professional judgement. So, we felt that it was an important step to take to try to review the guidance, and we have commenced that process.

There are other developments that we felt that we needed to take into account when reflecting new guidance. So, for example, the Safeguarding Board for Northern Ireland (SBNI) was not in existence in 2003, and its establishment was a significant step forward. Also, our understanding of certain kinds of threats to children and young people is developing and emerging. The use of social media as being something that can play a part in child protection was something that I do not think we were as aware of in 2003 as we are now. So, those were the reasons that led us to want to look at the existing guidance and undertake a process of review.

Work is under way and progress is being made. We hope to complete that milestone in accordance with the timetable that we included in the papers. It is challenging because this is interdepartmental guidance. One thing that we are very conscious of is the risk of unintended consequences in child protection. While we want to streamline procedures and make things as simple and easy to understand as possible, we are exercising considerable caution when reviewing each aspect of the guidance to try to make sure that the end result is as we intend it to be.

I hope that answers those points.

The Chairperson: I suggest that it is important to guard against unintended consequences across the piece. What I mean is that we need to ensure that all the processes are robust, can be defended and stood over, and even enhanced, if need be. The Committee is very clear, particularly given the issues

of the past weeks, that this is about safeguarding children, vulnerable children and young people. I make no apologies for saying that. Equally, it is about making sure that the processes are robust and effective.

Under that commitment and regarding vulnerable adults — I assume, Sean, that that is still within your remit — reference is made to mental capacity legislation. The briefing paper that we received says that the Bill will now be introduced in 2015. That is certainly news to the Committee. Can we get an explanation?

Mr Holland: My understanding is that the commitment was that the Bill would be introduced within the current mandate. Fortuitously, the mandate has been extended, and that has allowed us extra time. I have to be honest with you: had that not happened, there would have been a number of challenges in bringing forward the mental capacity legislation. They still remain. It was referred to, I think, very recently by the Committee when it said that it is incredibly ambitious and pioneering legislation. And so it is. I think that I am beginning to discover why it is pioneering and why no one has done it before. It is difficult. In particular, I think that the decision taken in 2011 to bring together justice provisions with the provisions relating to mental capacity within the remit of this Department has proved challenging. For that reason, we have instigated some processes to oversee the work. So, there has been a series of joint permanent secretary meetings between DHSSPS and the Department of Justice (DOJ) to make sure that the work is on track. We have been working very hard to ensure that the spirit of the Bamford recommendations is retained and expressed through the Bill. We continue to work on it.

The Chairperson: The Committee had been told that the process was imminent, that it was moving on and progressing. So, it is still news that we are talking about introduction in 2015. Can you clarify the timeline for the implementation going forward? I take the point, Sean, that it is ambitious legislation, but, equally, it is important legislation.

Mr Holland: It is. The first thing I would say is that the portion of the Bill that relates to civil society has, to a large extent, been drafted. There are a few pieces outstanding, but, broadly speaking, the portion that relates to the areas of responsibility for our Department have been drafted.

As for the timeline, we aim to have the Bill drafted in the spring of 2014, with ministerial and Executive agreement to publish the draft Bill for public consultation being sought between May and June 2014. The public consultation exercise will commence in July and run to October 2014. I have to be very clear that we have tried to tighten the timescales as far as possible to make sure that we still meet the commitment. The analysis of the consultation responses and the finalisation of the Bill will happen between November 2014 and January 2015. Between February and March 2015, we will have clearance from the Departmental Solicitor's Office and Attorney General regarding the legislative competence of the Bill, leading to Executive agreement to introduce the Bill in April 2015, with final enactment in 2016.

The Chairperson: OK. Can I ask that we are kept informed of that timescale as it progresses?

Mr Holland: Absolutely. If it is helpful, Chair, we are happy to provide that timeline to you as an aide-memoire.

The Chairperson: That would be useful. Thank you.

Thirdly, on the overall implementation of Transforming Your Care, we talked about the implementation plan as a milestone. I know that the Department put together a strategic implementation plan that was presented to the Minister in, I think, June 2012. I raised concerns about the fact that it was presented in advance of the full consultation. That plan is not yet finalised; it is still a draft. I know that it has been recently revised, but I am wondering what the delay is.

Ms Catherine Daly (Department of Health, Social Services and Public Safety): That process is moving forward now. As you say, the milestone was the development of the strategic implementation plan, and that plan has been completed. I know that the Committee has written to the Department about some specific changes, and there will be correspondence coming back to the Committee very shortly about the specific changes that have been incorporated.

As we move forward with embedding the transformation process, the next stage of the planning process in the Department is the development of the commissioning plan direction, setting out the

targets and the basis for plans moving forward for the next financial year. Again, we expect to come to the Committee with that fairly shortly.

The commissioning plan direction will be all-encompassing, incorporating the normal services to be commissioned by the Health and Social Care Board, and taking account of the changes arising from the transformation and what that will mean for commissioning. All that — the commissioning plan, the transformation programme and the underpinning financial plan to deliver that — will be brought into a single integrated plan. In that respect, we have moved forward from the strategic implementation plan.

The Chairperson: Maybe I am not being clear. Has the strategic implementation plan now been agreed, finalised and signed off?

Ms Daly: It is in the process now of final changes —

The Chairperson: So it is not agreed.

Ms Daly: There are no further changes to be made, other than the ones that the board is putting in place, and it will be published on its website shortly.

The Chairperson: OK. But it is not agreed.

Ms Daly: No. There is some final detail.

The Chairperson: The draft that we saw two weeks ago included big changes that were not in the first draft produced by the Department in June. There were major changes in there, such as the equality impact assessments, which were not included the first time round. So, there has been a huge shift. It has not been finalised, and we should not suggest that it has, because it is not available on the Department's website as a finalised piece of work yet. I think that it is important that we acknowledge that it is not yet agreed.

Ms Daly: There is final tidying-up to be done, and it will be published shortly. Again, we will confirm the exact status of it to the Committee.

The Chairperson: OK.

Mr McCarthy: I think that this one is for you, Catherine. Commitment 80 is to reconfigure, reform and modernise the delivery of Health and Social Care services to improve patient care. What account has the Department taken of the views expressed on the integrated care partnerships (ICPs)? Are the key stakeholders, including particular health professionals, more supportive now than they were?

Ms Daly: Certainly the whole development of the ICPs is progressing. There has been extensive engagement between the board and the key stakeholders. As I mentioned in the earlier session, the committees have now been established across all 17 ICPs, and work is continuing to fully establish the membership of the integrated care partnerships. That is not something that will just be set in stone at a point in time, because there is learning to go through. The ICPs are building on the learning from the primary care partnerships, and that will be a continuous process. However, it certainly is progressing and is being put in place.

Mr McCarthy: How consistent will they be throughout Northern Ireland? Will they be the same in Strangford as they are in Derry, Foyle or other regions?

Ms Daly: There is an element of consistency in the membership of the committees. The integrated care partnerships are, as you know, multidisciplinary collaborations, and they will address different things in different areas. Learning will be shared across the ICPs, but a consistent model will be applied across Northern Ireland.

Mr McCarthy: The last thing that we want is people getting a service in one area but not others.

Ms Daly: Absolutely, and that is what we are saying about sharing best practice. Learning from the work taken forward by the partnerships will be spread across all areas.

Mr D McIlveen: I am glad not to be gagged any more. I have just a couple of quick questions. Commitment 79 is to improve patient and client outcomes and access to new treatments and services. How much funding has been set aside for that?

Ms Daly: I am sorry, but I do not have the specific figure for that funding.

Ms Thompson: A lot of that is around specialist drugs. Under that heading, £36 million is available for anti-TNF biological drugs in 2013-14. That is making a considerable difference to the waiting times in those particular areas. Of that £36 million, there is £27 million for arthritis, £4·6 million for psoriasis and £4·3 million for Crohn's disease.

Mr D McIlveen: I am always conscious of this question: is money always the answer to all our problems? Obviously, most of the time, the answer is no. Is there an issue around the licensing of particular drugs that needs to be addressed? Is the Department moving at the same speed as science on these issues? New medicines are coming to market with very clear, demonstrable evidence that they work for particular conditions. However, because of restrictions in licensing to use those drugs for those conditions here, there seems to be a blockage. Does something need to be done there? Is there something that we can do? I am sure that all of us around the table have come up against that issue in our own constituencies.

Ms Daly: The Department is engaged with the board on managed entry of new drugs, which involves looking at a range of issues. There are some specific arrangements in place. If there is a recommendation for a drug that is not normally procured, it will be subject to an individual funding request from the trust to the board. Guidance has been developed between the Department and the board on managed entry of new drugs, and that is exactly the issue that it addresses.

Mr D McIlveen: Do you anticipate that, if it were to go through, that will speed up the process?

Ms Thompson: There is huge reliance on the National Institute for Health and Care Excellence (NICE) processes across the UK. It is about picking those up and considering them in the Northern Ireland environment. That is about focusing on the effectiveness of the new drugs or technology appraisals. If NICE views those as appropriate, a process is worked through the board and to the trusts to allow people to have access within a reasonable time frame.

You are quite right though that this all takes significant additional funding, and that is one of the pressures on our budget. Not only do we have the pay and price pressures but the demography pressures of the older population. We also have the pressure of new advancements with clinical treatments and new drugs and the reasonable expectation that people in Northern Ireland should have access to those processes. Considerable effort is made to ensure that there is clarity about what is available and how people access that. However, I guess that you will always find a patient who feels that they did not get what they want in that process.

Mr D McIlveen: Commitment 44 concerns education. Coming at this from a constituency point of view again, do you feel that we may be at risk of focusing too much on education at the cost of treatment? A constituent who comes in to see us is not too worried about being educated. They want treatment to put the issue right. Do you feel that we are at risk of crossing that line and being too heavy on education and too light on treatment, or do you think that the balance is still right?

Ms Daly: There obviously has to be a balance in that area. Everything shows us that there is benefit in developing the education programmes. It is focused on people with chronic conditions and is about assisting people's ability to manage those. It does not replace treatment, and the focus on treatment is absolutely key. The intention is not to replace treatment but to support patients so that they can better manage their conditions. We will evaluate just how effective it has been. It is in addition to treatment; it is not a replacement for it.

Mr Gardiner: Under commitment 2, the milestone for 2013-14 states that:

> *"The HSC will have in place, all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from 1st April 2014".*

How are you implementing that?

Dr Elizabeth Mitchell (Department of Health, Social Services and Public Safety): We are on track for the implementation of that. As you know, we have a programme established in every trust for people up to the age of 71. The plans are to roll that out and extend the age group up to those aged 74. The board and trusts have been working on getting accreditation of the endoscopy units up to the national standards to ensure that we can provide more endoscopic procedures for both the treatment service and screening service.

You will also be aware of the public information campaigns. Those have had the benefit of increasing the uptake for the duration of the period in which they have been broadcast. However, we find that, a few weeks after the advertising campaign, uptake levels drop again. This year, we are taking a different approach and trying to smooth out promotion of uptake. We are trying to focus particularly on men, who do not accept the invitation to be screened to the same extent as women do, and on the Belfast Trust and the Western Trust, which have lower uptake levels than the other trusts. We are putting in place a range of measures, other than just TV advertising, and are working with the community and voluntary sector organisations to try to boost the uptake.

Mr Gardiner: Do they go through their GP, or do they go direct to the hospitals or wherever?

Dr Mitchell: You get a kit through the post and are asked to take the test in your home and send it in. The response has been very good. People have been very impressed by the speed of turnaround. Depending on the results of that test, you may be asked to do a repeat test or be invited to come for screening and an assessment at your local endoscopy unit. At that stage, it will be assessed whether you need a colonoscopy. There are a number of stages in the process before you get to the stage of being given a colonoscopy.

Mr Gardiner: I ask the question because bowel cancer is a killer disease. My question may help people out in the community to find out how to go about hopefully getting a cure. I really welcome it.

Dr Mitchell: If you are in the age group, you will receive the kit through the post. We would certainly encourage everyone, particularly men and people living in Belfast and Derry, to take up this invitation; it can save lives.

Mr Gardiner: Can people younger than 60 go for it? You talk about the 60 to 74 age group. However, if younger people have a fear they may have bowel cancer, can they go and have the check-up?

Dr Mitchell: If people are concerned on the basis of symptoms that they may have — for example a change in bowel habit or rectal bleeding — they should obviously go to their GP and discuss those symptoms and concerns. The GP will then assess whether they need to be referred to the hospital for further investigation.

Mr Dunne: Going back to commitment 79, last year we exceeded the 10% of the proportion of patients with stroke issues. Are we endeavouring to increase that this year? I know that we have moved on in our plan, but would it be fair to say that we are continuing with that good work to increase that figure? We met 11·5% of suitable patients, which is, to me, a relatively low figure. Are we endeavouring to increase that?

Ms Daly: That work is certainly continuing. We have not set a separate target —

Mr Dunne: I see that.

Ms Daly: — because we have set separate milestones for each Programme for Government commitment, so it is not a further target within the programme. Again, that target would be reflected in the departmental commissioning plan direction, and, moving forward, we would look at it when assessing what was achieved, what could be further achieved and whether there is a need to set a target or whether the process is such that that will continue.

Mr Dunne: Does 10% or 11% not seem relatively low, though? I know that it was last year's target and that it was met, but are we —

Ms Thompson: The target for 2013-14 is to maintain that 10%, because, obviously, new patients are presenting all the time. However, as Catherine described, we will be going through the process for the

2014 targets in the next few weeks and deciding whether our targets should be extended. You are quite right: there has been a focus on stroke in a lot of our material and services, and whether that target needs to be pushed out further would need to be looked at.

Mr Dunne: OK. This year we are looking more in commitment 79 at the well-being, education and employment of teenage mothers and so on. Are you saying that that is where the focus is this year?

Ms Daly: The focus will continue across the range of areas, but the specific milestone in the Programme for Government relates to the family/nurse partnership. Again, that work has not begun, but it is a key milestone for 2013-14.

Mr Dunne: Just generally, mental health is an issue that we hear a lot about, and it is a priority. Where does it sit in this programme?

Mr Holland: The mental capacity legislation is identified as a key measure to improve the safeguarding of vulnerable adults and children. So, there are actions, and the action of bringing forward the mental capacity legislation is relevant to the commitment to bring forward a package of measures to improve the safeguarding of vulnerable children and adults.

Mr Dunne: Yes, but generally, would it be fair to say that mental health treatment is not identified here as a key issue?

Ms Thompson: No. You are quite right that the Programme for Government commitments pick on specific areas right across our services. Therefore, not everything can be covered. We have only six commitments in the entire Programme for Government. We address things in a more general way through the commissioning plan process with the board and the trusts picking up, in the Department and down to the board and trusts, the specific targets and things that need to be achieved. That is, for example, where the mental health resettlement programme would come in, and discharges would come in to that process. So, that is all in the Minister's commissioning plan direction to the service. We have only six commitments. I guess that a lot of other areas could be looked at to be included in the Programme for Government, but those are the six that we have, and, therefore, that is what we are monitoring as we move forward.

Mr Dunne: Would it be fair to say, then, that mental health would tend to be a lower priority than those that are in those six?

Mr Holland: No, I do not think that it is fair to say that. The Programme for Government identifies particular areas where it is felt to be timely to have a specific focus on an area of activity. Were you to look at the mental health actions that my colleagues told you are in the commissioning direction, you would see that there is a substantial raft of activity. A few years ago, Bamford was one of the reasons that we decided that we needed to shift our focus, so we had an explicit review of mental health. That has now been mainstreamed into our regular business planning processes, which, indeed, will be the case for a number of these issues in years to come. They will no longer exist as Programme for Government commitments. However, that will not mean that they are no longer priorities; it will mean that you will find them in commissioning plan directions, in departmental business plans and in trust delivery documents and so on.

Mr Beggs: You indicated that this is a live document that changes to a degree as issues come along. One of the Northern Ireland Audit Office's criticisms of the previous Programme for Government was that it did not particularly meet specific, measurable, attainable, relevant and time-bound (SMART) objectives, so some of its targets were hard to measure. Can you provide us with a track of all the changes that have been made so that we can have some understanding of why they have been made and so that we can be satisfied that they continue to have SMART targets and are not just changes for the sake of making them move from red to orange to green? I think that it would be useful if we were to have a track of all the changes that were made.

Ms Thompson: The living document aspect surrounded the Programme for Government delivery plans. However, as I said in my opening remarks, neither the milestones nor the commitments have changed in those processes, though you want to keep up to date your assessment of risks and of actions in the milestones and commitments. I guess that part of the process involves coming back regularly to the Committee with the delivery plans so that you are kept abreast of what is happening. So, we can provide the Committee with tracked changes of each of the delivery plans, if that is helpful

to you, or we can come back regularly and help you to understand where the differences are — whatever the Committee wants. We keep them up to date as part of the OFMDFM process anyway. That is an ongoing process that is done on a quarterly basis in the Department. So, we will do whatever the Committee wishes on that.

The Chairperson: I suppose that this is about making it as accessible and easy to track as possible. It really should not be that difficult. It would be useful to do both: to provide us with the written tracking process and to have those regular updates, which are very important. We are dealing with six commitments. Granted, there are three milestones under each of those, but it is not a huge list of objectives. So, I think that the information should be easily passed back and forward.

Ms Thompson: I am happy to do that, and, as I said, that is done on a quarterly basis. I give you the reassurance that, right from the start of the process, we have not touched a milestone or a commitment. Therefore, the assessment of reds, ambers and greens is completely kept on a consistent basis through the process. So, there has been nothing of that nature to concern the Committee.

Mr Beggs: Commitment 80 is to:

"Reconfigure, Reform and Modernise the delivery of Health and Social Care services".

Milestone 2 of that commitment is to reduce by 10% the number of days that patients stay overnight in acute hospitals unnecessarily. The milestone describes that as "excess bed days", and it is commonly known as bed blocking. The target is to reduce that by 10%, so, under that target, we will maintain 90% of the excess bed days in the system. I see that we are on target to meet this challenge, but was that a sufficiently challenging target, given the cost to the system and to patients who do not get treated because others who do not need any treatment are occupying beds but the system does not enable them to be cared for elsewhere?

Ms Daly: You described what excess bed days are, and the objective is absolutely not to have any such days. However, lots of factors contribute to that, including discharge into the community. The target of 10% is set to reduce excess bed days. Ensuring that the proper services are in place in the community in primary care to enable effective discharge should assist in bringing that down further. As Julie said, we have milestones for each year for the targets under the Programme for Government, but, internally in the Department, we look annually at all this in the context of the targets under the commissioning plan direction so that that features in the commissioning plan. Again, the extent to which that has been achieved will be looked at, as will the extent to which it is continuing and to which it needs a further target to drive it down or whether, in fact, services are being delivered in such a way that means that it is driving it down without the need for a target. We have 29 targets in the commissioning plan direction in the current year. That is just a number of things for which targets are deemed appropriate. However, the commissioning plan direction itself covers the raft of services and strategies from the Department and how they should be delivered. Ideally, we would not want to have a target there, and also ideally, this is something that should happen. However, we will look at that in the context of the commissioning plan process.

Mr Beggs: I was talking to a senior clinician last night. They indicated that bed nights in hospital is one of the highest risk factors that affects your life expectancy, because the more you stay there, the more you are at risk of exposure to other illnesses. I question whether we have put sufficient priority into enabling people, when they are ready and have been treated, to move on to a better environment to allow that very expensive and specialist bed to be used for treating others.

Ms Daly: I absolutely take your point. This is just one element of how we are looking at this matter and ensuring that services are where they should be and that people are treated nearer to their homes and are not staying in hospital. That is the key focus of TYC. So, there are a number of ways in which we will look at that, but we would consider that specific target in the context of the commissioning plan process.

The Chairperson: Folks, thank you for your attendance. I look forward to the follow-up, particularly where the finalised draft of the strategic implementation plan is concerned.

Mr Gardiner: Could I come in with a wee question?

The Chairperson: If it is quick.

Mr Gardiner: What inroads are you making with people who suffer from dementia? Recently, I went to visit some of my constituents. It was so, so sad to see big men carrying wee cloths and women carrying dolls. Is there a cure or a breakthrough anywhere for people who suffer from dementia? Is there any hope of that?

Mr Holland: I will start by saying that there are a number of developments in how we care for people with dementia that I think are very promising. Those developments are connected to supported living schemes, nursing home care and our understanding of how best to care for those people. Unfortunately, an actual breakthrough or cure is something that I do not have any particular knowledge of.

Mr Gardiner: Can you tell me anything about drug treatment? Are you working on it? Is anyone working on it? Are the doors shut, leaving those people closed off?

Mr Holland: My understanding is that a very significant amount of money, nationally and internationally, is being put into research into drug treatments for dementia. There are some drugs on the market now, which is a development of recent years, but I would defer to my colleague Liz Mitchell about the nature of those drugs.

Mr Gardiner: I know that we are pushed for time, so rather than go through it all, could we have a report on what success you are having and what inroads you are making? Is there a glimmer of hope that we can get a cure for dementia?

The Chairperson: Absolutely we should seek a view, but it is probably slightly outside the Department's remit. I suggest that it would be useful to get your views on how we, the Department and Committee collectively, respond to and deal with the fact that we have increasing levels of dementia.

Thank you for your attendance today.