

Northern Ireland Affairs Committee

Oral evidence: [Funding priorities in the 2018-19 Budget: Health](#), HC 1447

Wednesday 5 September 2018

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Members present: Dr Andrew Murrison (Chair); Mr Robert Goodwill; John Grogan; Lady Hermon; Kate Hoey; Jim Shannon; Bob Stewart.

Questions 1-58

Witnesses

I: Valerie Watts, Chief Executive, Health and Social Care Board, and Interim Chief Executive, Public Health Agency, Dr Miriam McCarthy, Director of Commissioning, Health and Social Care Board, Dr Adrian Mairs, Director of Public Health, Public Health Agency, and Paul Cummings, Director of Finance, Health and Social Care Board and Public Health Agency.

Examination of witnesses

Witnesses: Valerie Watts, Dr Miriam McCarthy, Dr Adrian Mairs and Paul Cummings.

Q1 **Chair:** Good morning, everyone. Thank you for coming to talk to us today. As you probably know, we are taking it upon ourselves, as the Northern Ireland Affairs Select Committee, to look at a number of areas of public policy in the light of the situation in Northern Ireland at the moment, particularly the absence of the Executive and the absence of Ministers. Our cue for this is the fact that a budget has been set here at Westminster, which has been constructed, one assumes, by officials in Northern Ireland to represent the needs of Northern Ireland, and which has been approved and by, and therefore endorsed by, Ministers here in Westminster. That gives us our cue as a Select Committee of this House to investigate those areas of public policy that would have previously been the responsibility of Stormont but, sadly, in the abeyance of Stormont, is not.

What I would like to do very briefly is ask you, Valerie, if you might like to introduce the team and say how the organisations represented here fit together for the benefit particularly of those of us who do not represent constituencies in Northern Ireland and who may not be entirely familiar with the structure. If you could do that very briefly, I think that would be helpful.

Valerie Watts: Thank you for that opportunity. Good morning, members of the Committee. I am Valerie Watts, and for the last four years I have been chief executive of the Health and Social Care Board for Northern Ireland, which is a very privileged position that I hold. For the last two years, come the beginning of October this year, I have also held the position of interim chief executive of the Public Health Agency. On the retirement of Dr Eddie Rooney almost two years ago, the then Minister asked me if I would step into that interim role. There is a lot of reorganisation taking place among senior structures in health and social care at the moment. You clearly will know that there was a ministerial decision to close the Health and Social Care Board. We are working towards a date of closure of approximately 31 March 2020, so a fair amount of reorganisation is taking place across health and social care organisational structures at present to fit around the whole transformation agenda.

On my left is Mr Paul Cummings. Paul is the director of finance for both the Health and Social Care Board for Northern Ireland and the Public Health Agency for Northern Ireland. Paul has been with the board and the Public Health Agency since the beginning, when they came into being in about September 2009.

Directly on my right is Dr Miriam McCarthy. Miriam has a wealth of experience working across the Department of Health, in the trusts and also in the Public Health Agency, to name but a few organisations. Miriam



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is currently in the position of interim director of commissioning within the Health and Social Care Board.

On my far right is Dr Adrian Mairs. Adrian is the interim director of public health within the Public Health Agency and has a wealth of experience working across many of the organisations within the health and social care system in Northern Ireland.

Clearly, we work in a very integrated way. We need to work in an integrated way within the health and social care system in Northern Ireland, not just the working arrangements between the Health and Social Care Board and the Public Health Agency but with our colleagues in the Department of Health, our colleagues in the provider trusts, GP colleagues and, even more importantly, with the general public, patients, carers and clients in relation to the services that we provide. I am happy to say that coproduction is very much an overarching theme in relation to the whole transformation agenda. It is something that came out of Professor Bengoa's expert panel report, and that has set the tone very much for how we want to work with each member of the population in Northern Ireland, for the delivery of the best possible health and social care services for the 1.8 million people.

We like to use the phrase "working collaboratively for collaborative gain" across all of the healthcare partners, but particularly with the general public, for the delivery of hopefully the best possible model of health and social care in Northern Ireland. I think it is appropriate that I remind members of the Committee today that we have responsibility for health and social care budgets in Northern Ireland combined, unlike our counterparts in Scotland, England and Wales, where social care largely sits within local authorities.

Q2 Chair: Indeed. Maybe Northern Ireland is leading the way in that respect and we might look forward to something a little more rational in GB in the fullness of time.

Can I start with some reflections on the state of healthcare in Northern Ireland at the moment? The scores on the doors really are not at all promising, as I am sure you are acutely aware, with the latest quarterly figures on waiting times being disappointing, with performance in A&E being among the worst in the United Kingdom. That will cause you a great deal of concern and, although I am sure that you are working, as officials, extremely hard to rectify that so far as you possibly can, I am wondering about the extent to which the absence of Ministers capable of making decisions in this area is impacting, or could potentially impact, upon the state of affairs and, in particular, your ability to make changes, some of which you have already hinted at.

Valerie Watts: Maybe I could open the answer to that question and then I will pass to Dr McCarthy, who might be able to give some more of the detail, Chair.



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As members of the Committee are undoubtedly aware, the system works best when a Minister is in post, and indeed it is the Health Minister of the day who sets the strategic direction for health and social care in Northern Ireland. It is also the Health Minister who holds the system to account, and he or she also in turn is accountable to the electorate through the electoral process. Clearly, in the absence of a Minister it is more difficult to oversee effective transformation and to be running day-to-day services as there are a number of very challenging decisions that need to be taken, not least in relation to enabling the whole transformation programme—I am sure the Committee will want to question us about transformation funding shortly—and to put all of that into a longer term financial planning base.

However, we believe that the political summit hosted by the expert panel back in February 2016 secured a political mandate for the need for change in the principles that underpin the whole delivery of health and social care in Northern Ireland. There was a clear mandate and agreement as well that transformation is absolutely critical in order to develop a sustainable health and social care system moving forward.

Obviously, there needs to be greater clarity across all Government Departments about what decisions can be taken in the absence of a Minister, and indeed by senior civil servants. I say that in relation to the Hightown incinerator case that has been highlighted recently. Notwithstanding all of that, the permanent secretary, Mr Richard Pengelly, has put in place a very robust set of accountability frameworks that are ensuring transformative programmes of work. We believe that they are being delivered effectively and efficiently. I am happy to give a bit of a readout on that slightly later on in today's session if that is required.

For us, it is very much business as usual. There are existing or extant policies and mandates in place that we are still adhering to and trying to deliver the best possible health and social care, and indeed transformation programmes in relation to health and social care, as we possibly can, although there are some very challenging circumstances that we are operating within at the moment in Northern Ireland.

Chair: We are going to come back to some of that shortly, but before we do I am going to come to John Grogan.

Q3 **John Grogan:** You mentioned the transformation agenda, which I think, having read up about it over the weekend, goes back to possibly 2011, if not before, with "Transforming Your Care", and then there have been other reports and so on. How is it going?

Valerie Watts: It is going extremely well. We believe that we are making a fair degree of progress in relation to the transformation of the whole health and social care system. The Department of Health did produce a report back in October 2017, just one year on from the issue of the "Delivering Together" strategy document by the then Minister. There



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has been a significant range of initiatives that have been taken forward with the comprehensive accountability framework. That is all underpinned by effective partnership working.

I think that the "Delivering Together" strategy and the action plan builds on the very strong foundations that were also laid down by "Transforming Your Care" and other programmes of change that have since been introduced, as I said, on top of Professor Bengoa's report. However, I think that I will hand over to Miriam, who will speak about some of the more detailed work that we are undertaking at the moment in relation to that.

Dr McCarthy: It might be helpful to have a couple of examples that also respond, Dr Murrison, to your questions about unscheduled care and elective in particular. We know that we have significant challenges on unscheduled care. If we look back at last winter, for example, we know that people were waiting long periods of time in some instances in ED departments. Indeed, I think that was a common picture across all of the UK in the winter.

We have looked at that and tried to understand what was happening. While most people are dealt with fairly quickly, there are a number of people who will need to wait potentially over 12 hours, and the issue is getting them a bed in the hospital. Looking at last year, we were aware that people being admitted are older and that is no surprise; we have an ageing population and it is a testament to how well we have done at keeping people healthy that they are living longer. They are also sicker. The people being admitted to hospital definitely have more morbidity and are sicker, frailer and, therefore, have longer lengths of stay.

A few of the examples of things that we are doing that are transforming our services focus partly around admission avoidance. We do not want people in hospital unless they need to be, and I think that all of us would want that to be the case for ourselves. We are setting up services and some are well under way and well established and others are being established at the minute through the transformation funding, services called Acute Care at Home, where we are aiming to keep people in their homes who would otherwise have been admitted. So far that is working very well. Obviously, those individuals need medical care and nursing care, but that is being provided in their homes. That is one way of providing quality in their homes, promoting better rehabilitation after their particular episode, and providing the necessary medical and nursing support. That is at a relatively early stage. We hope to expand that. That has been very well received and we are working very collaboratively with trusts on that.

In terms of getting people out of hospital, because we really should not be holding on to people longer than necessary, again as part of the transformation work we are creating a service called discharge to assess. Instead of doing the assessment for people to describe their health



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and/or social care needs in hospital, we want to get them home and assess them in their own familiar surroundings. That is better for the patient, better for their family and hopefully much better at being accurate about their assessment needs, seeing people in their familiar surroundings.

Getting people out of hospital when they are medically fit to get out of hospital is a challenge, and I know it is not a challenge alone for us in Northern Ireland. It is a real challenge that we are focusing a huge amount of attention on this winter. It is much better, particularly for older, frail people, to be back in their own homes, so we are doing everything in our power. That is driven by the transformation agenda and us wanting to improve the quality of healthcare.

Q4 John Grogan: I have a couple more questions, back to the role of Ministers in relation to this transformation agenda, which basically, as I understand it, is more on primary care and less in the hospitals. When anything is changing there are always going to be those who are resistant to change. You mentioned the role of Ministers in taking decisions and accountability, but isn't there a role also in championing, banging heads together occasionally, going out there and opening the new facilities, getting in the press, taking the public with you? Am I being overromantic or is that something you miss about Ministers?

Dr McCarthy: First, I think that you are absolutely right that we need champions in everything we are doing, and Valerie already referred to coproduction. Importantly in what we are doing at the minute, we need clinical champions, and we have a lot of clinical champions. That clinical leadership is absolutely key, whether it is in the secondary care sector or the primary care sector. We also need patients and carers participating in that. We have found in many areas of work that the patients and carers act as very good champions and facilitate the change. Of course, in any area where we are looking at doing things differently, there will always be a little bit of resistance and sometimes that resistance is a very healthy questioning about the need for change and the way we are changing.

We have those champions at the moment and we are trying to drive things forward. We have had very good support in numerous areas from patient groups who want things to be done differently and with whom we are working together. That is a key component of how we are trying to progress these measures.

Valerie Watts: To add to what Miriam has already outlined, as I alluded to earlier the permanent secretary has established a transformation implementation group. That is chaired by the permanent secretary of the Department of Health and is comprised of senior leaders from the Department of Health and across all the HSC trusts and the chief executives from the board, the Public Health Agency and the Business Services Organisation. In the membership of that transformation implementation group we have a leading consultant surgeon and a leading general practitioner, both of whom also sat on Bengoa's expert



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panel. We have met fortnightly since the establishment of that transformation implementation group.

I would have to say that we have also been tasked with, and willingly undertaken, the role of being leaders in the transformation agenda. We play a particular role in relation to the oversight of the design, development and implementation of transformation, and we are working across all the traditional boundaries and siloes to try to lead and manage that particular change agenda.

Q5 **John Grogan:** A transformation fund has been set up, hasn't there? Is it enough? Will you need more in the future or is it satisfactory for your purposes?

Valerie Watts: I can start the answer to that question and hand over to the director of finance, who can supply some more of the detail.

In relation to the transformation funding, we certainly welcome the additional £100 million of funding for this year. Everyone in Northern Ireland believes that transformation of the health and social care system and the service we provide is critical to the longer term sustainability of health and social care in Northern Ireland. Obviously, the transformation fund is a £200 million non-recurrent investment over a two-year period beginning in the current financial year, but we do believe that this transformation funding will offer a very unique opportunity to progress key actions that will enable a broader change agenda within the vision for transformation.

I want to hand over to Paul, who can talk through a bit more of the detail perhaps in terms of how that transformation fund is being allocated.

Paul Cummings: I suppose the challenge with the transformation fund is that it is non-recurrent in nature, so to go from a standing start to £100 million of spend for just two years is, as you would understand, extremely challenging. We have to recruit an additional 1,200 staff to deliver the projects that are within the transformation agenda, and Northern Ireland is finding that challenging. We have vacancies at the moment within our core services. I think over the next couple of months, as we go to the implementation phase of the transformation agenda between now and December, we will see how successful we are in filling those posts, but for me as director of finance we are starting on an agenda that will continue. Transformation is not something you do and then stop; it continues. The funding in the long term of the £100 million will be challenging in two years' time and it is something we have to be aware of now.

Q6 **Chair:** That sounds like it could be quite wasteful. If you are wheelbarrowing money on to a solution in the short term but there is no long-term plan, the danger is that you, as director of finance, with your colleagues, will try to spend all that money and then you will find that you have to retrench to an extent when the money runs out. Is that a



concern?

Paul Cummings: It is a concern. We have to ensure that we will identify the funding from the core services and whether that is additional savings. The hope is that a transformation starts to reduce the demand in the future. The challenge will be that two years is a very short timescale to turn that demand curve. If you were looking at five to 10 years, then transformation has a chance of turning the demand curve down from the 4% to 6% that it is currently. In two years that will be extremely challenging.

Q7 **Chair:** To what extent were you involved in the structuring of this welcome injection of funds? I suspect that you, as a financial person, would have preferred this spend to be much better profiled.

Paul Cummings: We had no involvement. This was a decision taken by the Government in the confidence and supply deal, so we were not involved in the setting of the fund. The fund was ring-fenced at £100 million, and we also have some—

Q8 **Chair:** I think that is the problem, isn't it? This money was determined, as you say, politically and you now have to play catch-up in trying to work out a way to disburse that funding in a rational way. The problem we would have with that is that it would potentially be quite wasteful.

Paul Cummings: I hope it won't be wasteful, because I think the projects that we are spending the funds on are the types of things that, if we had more funding in our core services, we would want to be doing anyway, but because our core budget, which I am sure you will examine later, is so constrained, we have very little development funding. I do not believe that any of the money from transformation will be wasted—far from it. I think that it allows us to pilot things in certain areas to ensure that they work before they are then bid for full recurrent funding to roll out to the whole of Northern Ireland.

Q9 **Chair:** Aren't you now scratching around trying to work out how to spend this money? I am sorry; that is a slightly pejorative way of putting it.

Paul Cummings: I could not hear you clearly, Chair.

Chair: Are you looking for projects on which to spend this money so that you do not come to the end of the period and find that the money has not been spent?

Valerie Watts: Considerable work has been done to identify quite a comprehensive list of transformation projects that has been brought to the transformation implementation group for approval. There is a view that these will be truly transformative in nature and considerable effort has gone into preparing the business cases to support each of those projects in taking them forward, along with the allocation of specific amounts of money to deliver those projects.



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However, I would say at this stage—and I am sure I am preaching to the converted when I say this—that reforming a complex health and social care system does not just happen overnight. Much of the work that has already been undertaken so far is the kind of necessary preparatory and enabling work that is not always immediately visible. We are building on all of those foundations. We have our list of transformation projects. We are allocating the money at the minute. One of the core challenges for us, however, will be recruiting the workforce to resource those projects. We are currently facing a bit of a resourcing crisis in Northern Ireland, with the number of vacancies we are carrying across the health and social care system. We have identified, as part of this preparatory work, that we also need to recruit approximately an extra 1,200 people across various medical, nursing and supporting disciplines, particularly in social care, in order to resource these transformation projects.

Q10 Chair: How should Ministers be involved in decision making at the moment? You have mentioned a number of projects—Miriam, I think you referred to Acute Care at Home. Normally, those sorts of things would be dealt with by Ministers here, in Richmond House. Clearly that is not happening in Northern Ireland right now. Do you feel sufficiently empowered to make those kinds of decisions that would normally be the province of a Minister, particularly in the light of the recent court decisions about the incinerator, to which you referred?

Valerie Watts: Clearly, Chair, as I have already established, there are existing policies and mandates within which we are working. We very much take our direction and instruction from colleagues in the Department of Health, who again are working under existing or to existing political mandates and policies. There are challenges around some of the critical decisions that would need to be taken in order to carry forward some of these transformative agendas, and it would always be better to have a Minister in place to be able to make those critical decisions. Perhaps your question is more geared towards the politicians. We have to work within existing policies.

Q11 Chair: Are you concerned about being challenged legally on some of the decisions you are making on these projects? As we have touched on, and as John Grogan pointed out, healthcare issues are always controversial and there will be people who take a contrary view and potentially apply for judicial review on some of them. How are you safeguarding against that possibility?

Paul Cummings: We are fully aware of that and we are concerned at times. Therefore, in the changes that we have been making we will not be potentially closing services. You are less likely to be taken to court if you are developing services than if you are restricting access to or closing services. Consultation is not possible at present, so we are very clear that we cannot go out to consult on service changes. There are things we want to be doing to bring our service offering in line with some of the changes that have happened in England and Wales that we are not able to take forward or we are not able to pursue. The Minister has not given



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a view on the recent review of adult social care, so we have no strategic direction from a Minister on "Power to People", for instance. We have no view on charging, which is one of the proposals that we may want to examine to come into line with the rest of the UK. Those are areas where we have no ministerial view and cannot take forward at this present time.

Q12 **Chair:** Would I be correct in characterising that as being risk averse?

Paul Cummings: I could not comment.

Chair: Or policy light?

Paul Cummings: We have challenges.

Q13 **Jim Shannon:** Thank you so much for coming over to make representations to the Committee. In the initial response to John Grogan, Valerie mentioned "Transforming Your Care". Do you have any indication of what percentage of "Transforming Your Care" has been delivered so far? Is there any way of quantifying how much of that has taken place?

Paul Cummings: Are you talking about "Transforming Your Care" or the £100 million of transformation funding? Unfortunately, the word "transformation" is in both.

Jim Shannon: "Transforming Your Care".

Paul Cummings: TYC was the John Compton report.

Jim Shannon: Yes, that is the one.

Paul Cummings: That has been fully implemented.

Q14 **Jim Shannon:** The moneys that came in on the back of that, Paul, how much of those moneys have been—

Paul Cummings: The "Transforming Your Care" or the confidence and supply deal?

Jim Shannon: The confidence and supply moneys.

Paul Cummings: On the confidence and supply money, we have currently spent about a quarter of the £100 million. There are several sources of funds. The transformation is £100 million. In the core budget we also got an additional non-recurrent £60 million and £10 million for mental health. We have this year within health received £170 million from confidence and supply.

If I can deal just with the £100 million, we have spent significant funding on elective care and we have commenced some of the early projects on training. Our main spend will take place in the last quarter of this financial year and then following for the 18 months thereafter.

Q15 **Jim Shannon:** We will expect to see a large improvement in the final quarter as the financial year comes to an end?



Paul Cummings: That is our current plan; that our spend is heavily weighted—

Valerie Watts: Sorry, Chair, with your indulgence maybe I can just, for Mr Shannon's purpose or information, outline some of the high-level breakdown of that particular investment, in case you want to question us further about some of the detail.

Chair: Yes.

Valerie Watts: Out of that £100 million transformation available for this year, roughly £30 million is targeted at stabilising the system by stemming the increase in waiting times for both diagnostic and elective care. Some £15 million has been identified for investment in primary care, and that includes £5 million for the initial roll-out of an operating model for multidisciplinary team working within GP practices. Again, we can give you some of the detail on that. Some £15 million has been identified for workforce development right across the whole health and social care system, and up to approximately £30 million of investment in reforming hospital and community services. That includes investment in the establishment of new elective care centres. Almost last but not least is £5 million investment in building capacity in communities and in health prevention approaches, and £5 million investment in what we call the enablers for transformation, including investment in those coproduction areas of work that I outlined earlier, and also, equally importantly, in the whole development of quality improvement initiatives.

Q16 **Jim Shannon:** I am sure those figures will be available for the Committee, just to give us a bit more meat on the bones. Forgive me, but I have a fairly severe dose of the cold and my voice might go in the middle of all this, but I hope it doesn't—some people probably wish it would go, but that is by the way.

I have some questions about the elective care. What you have put forward there are some good reasons or good solutions, but they perhaps do not address the initial care of the elective care needs. Would you have any idea what moneys would be needed to deliver on the elective care waiting times to bring them into the target times? The fact of the matter is that, as elected MPs from Northern Ireland—Lady Sylvia and myself are the two here in the Committee at this moment—we are very aware of the waiting times. The figures are serious. I am my party's health spokesperson, so I get a lot of referrals on these issues. I am not here to criticise anybody, but I am just going to make the point that people are waiting quite some time for a cancer diagnosis.

I was at a meeting yesterday, Mr Chairman, to do with a special cancer service, and the doctor who was there explained to us how the system works. How that system works is complex and detailed to get the diagnosis and to find out exactly what is wrong with the person. It is not simple—far from it. I have been to Queen's University to see the things that they do in the investigation of cancers as well, so I am well aware of



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some of the detail. The fact of the matter is that the targets that they are set are not being met, and they probably will not be met without extra moneys either.

You mentioned diagnosis. Back when John Compton did "Transforming Your Care", Simon Hamilton was the Minister and he was very much into prevention and early diagnosis. If we want to address the real core issues of health, we need to address those issues. The thing is that when it comes to bringing down the elective care waiting times to target levels, are we going to try to achieve that in this financial year, even partially?

Dr McCarthy: I can respond to that. First, you are absolutely right; there are real challenges in elective care with outpatient appointments and diagnostics and treatment. The £30 million being spent this year to improve elective care, which is being focused on patients waiting long periods of time and in diagnostics, will help, but it would be unrealistic to think that that will sort the problem completely.

There are a number of other measures underway that will also help, particularly with outpatient waits. There is a question of whether people need to be referred to an outpatient clinic. There are a number of measures under way to have virtual clinics, GPs being able to get advice on e-triage rather than patients having to travel. That can help manage demand very well. Some of the initiatives driven by the transformation funding to establish multidisciplinary teams in primary care will help manage more patients in primary care. There are also quite a lot of measures to look at ongoing follow-up, with people who attend outpatient clinics for the management of their condition, potentially for years. Can they be discharged from hospital care and returned if their GP needs to refer them again? We have done that very successfully across cancer specialties, but there is certainly room to do it across other specialties and we are looking at that.

All of that will help, but we do have a very significant challenge in elective care. I think that it will take more time to get that into balance and we will need to be doing a comprehensive suite of measures in managing demand, having more appropriate pathways, utilising our technology to have e-triage and virtual clinics and discharging people from care where we can manage to do that.

On the cancer pathways in particular, we have two targets. One is that from referral people should be seen and have their definitive treatment within 62 days. The other is that after diagnosis people should have their definitive treatment within 31 days. We do very well on the 31-day target; the vast majority of people, once they have their diagnoses, are treated within that period of time.

The more challenging area is the 62-day pathway, because that is the part that involves all the diagnostics. Sometimes what we call the conversion rate—how many people referred will actually have cancer—can be very low. For example, for women with breast lumps referred to



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an outpatient clinic, something like one in 20 will have cancer and the others thankfully will not and will get that reassurance, but 20 people have to be seen and assessed for one diagnosis. Within that 62-day waiting time we have the difficulties with gastroscopies and colonoscopies and waiting times there, which we are trying to put more funding into this year as part of the elective package. I accept that we have some way to go on that.

Q17 Jim Shannon: For the record, Mr Chairman, I think it is important that we do recognise the fantastic work that everyone within the health service does, and not just in Northern Ireland but across the rest of the United Kingdom. The work that the nurses, doctors and all the staff do is incredible, but they are all working within a very tight system. It is just that the issue of cancer came to my attention yesterday. I am not fully aware of how you could do a diagnosis and do a biopsy and that biopsy needs to be more intensive to find out, and I was given an example yesterday of how it needs to be done. It makes me think that perhaps sometimes the diagnosis needs to be more intensive than perhaps it is.

An issue that I get regularly is about home care and discharge from hospitals to homes and the importance that the hospitals have in releasing beds for other patients to come in. It is a very complex and difficult system to try to work, but at the end of the day I am also aware when it comes to home help and home care that it is a massive issue in the area that I represent, and I suspect maybe for my colleagues as well. We have had some companies who are pruned to the very core when it comes to delivering a service, such is the contract that has been set and perhaps their financial difficulties in trying to meet that. We have had some care companies that have gone out of business in the middle of a contract, which is terribly worrying. It means a gap has to be filled urgently and it usually falls back on the local trust and healthcare in the area to try to deliver that.

When it comes to ensuring that we do not have those difficulties and also to ensure that when it comes to someone being discharged from hospital we have the care system in place and we are not sending someone home with, "Yes, we will get that organised for you," I know people who have asked me what to do. I say, "If you do not have a care package whenever you go home and you are very ill, you are better to stay in hospital." You just tell them that. Sometimes you have to force things on where the pressure is to make it happen so the care service can be delivered. When it comes to care and home care and having a contract that firms can deliver on, how do you see that improving? Will some moneys go to improving that in the short term?

Paul Cummings: That is one of the main areas that we are looking within the transformation funding to reform, Jim. We recognise the challenges that we have within Northern Ireland on domiciliary care at present. We have over many decades moved from providing this service from within the health and social care sector to outsourcing it, as you say, and ultimately trusts now have the requirement to tender it. It is led



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by a price and the quality and those two things combined result in the successful bidder being awarded the tender.

We need to re-examine, as the "Power to People" review of adult social care said, how we value domiciliary care workers. Paying them the minimum wage is not acceptable in this day and age; they require a skillset that is not a minimum wage job. We need to change how we as a society value them. We need to re-examine whether we as a society are prepared to pay and contribute to that, because we are the only part of the UK where domiciliary care is free. The rest of the UK contributes to that cost, so that is another area we have to look at.

We are at present within the transformation fund looking at increasing the wage of those workers, reprofiling how they work so they get a more rewarding job, ensuring that there is a career structure for them, that they can progress, and that ultimately it is a job that when you are leaving school you want to take; it is not seen as a job that is the last job you want to take. It is a very challenging job to go into somebody's home four times a day in the middle of winter and you may be the only contact that person has that day. We need to value that job and ensure that we bring more of it back in-house and people see it as a rewarding, long-term career.

Q18 Jim Shannon: That is one of the main issues that I deal with regularly in my office. Personally speaking, I have a brother who was seriously injured in a motorbike accident. He is cared for at home and the carers come in four times a day, but the trust works on a system where we employ someone to come and do that and that is how the system works. In a way, we control the carers who come in through the companies.

What I am aware of from others who are delivering care is that they are given a 10 or 15-minute allocation time to go to someone's house, which sometimes can be to get them out of bed and make them breakfast. I do not know how fast you can work and how delicate you can be in the time that you do that in, but it is almost impossible to deliver in those timescales. When you set a tender or you set a contract or you set a system, there are many people who will try to deliver within a time and probably do more than the time they get paid for. For some of those people, they are the only people you meet in that short time they are there. That is one of the key issues that I have.

Can I ask very quickly about the issue of out-of-hours? I think you mentioned it, Valerie. That is where the system is under big pressure in my constituency. Again, since we are talking about health in general, you know the pressures. Doctors came up with a system and suggested to me a system when I met them some time ago, earlier on this year. They came up with a system that was to change how the out-of-hours works and bring in maybe more experienced nurses to also help out of hours. The point I am trying to get to is that here are other methods of doing things, which those with expertise and knowledge have thought up, but here we are at crisis point again with out-of-hours where doctors are



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under pressure. Some of the out-of-hours doctors do not have the GPs that they once had. Has there been any help to address the issue of out-of-hours?

I will just ask a second question about pharmacies. Again, it is something that I have a particular interest in. Lots of people have contacted me about pharmacies. I think that we can do a system differently and better, if I can say this honestly and very gently to everyone who has much more knowledge than I have. Pharmacies can be the frontline for diagnosis and for minor treatment. They can take some of the pressure off the health system. I am wondering what discussions you may have had or what thoughts you have on how we address those issues. Those are two things that could currently help take the pressure off our health service where the key emergency points are at this moment.

Chair: Can we have some fairly brief answers?

Paul Cummings: We agree that pharmacy has a fundamental role to play in the provision of health and social care within Northern Ireland. We have challenges around the funding envelope and we probably have ongoing discussions with our pharmaceutical colleagues as to what the funding envelope for pharmacy should be. We have to remember that we are funded on a capitation share and get the same per head of population roughly as the rest of the UK, but we have 12% more pharmacies than they have elsewhere in the UK. We have efficiencies that we need to ensure that we are getting a cost-effective pharmaceutical service, and we have made significant inroads into improving the efficiency. I believe that with the transformation funding and using pharmacy to maybe access some of that funding we can change and use more of the pharmaceutical services that are available, because it is a great expertise that they have. They are the first point of contact for many patients when they feel unwell, and we want to maximise the benefit we can get out of that and use them to prevent people going to other services that are inappropriate.

Valerie Watts: If I can address your questions in relation to support for GP practices, Mr Shannon, you are undoubtedly aware that a major transformation initiative has just been confirmed at the weekend past for GPs. It has been decided that GP federations in both Down and Derry/Londonderry will be the first to benefit from what we call multidisciplinary teams sitting within these practices. For Members' information, multidisciplinary teams involve the establishment of practice-based physiotherapists, mental health specialists and social workers at those GP practices, and they will now work alongside doctors and nurses to better meet the demands of the local population. This model clearly involved significant investment in additional nursing specialist roles, such as health visiting and also in district nursing. These multidisciplinary teams—MDTs, as we refer to them—we believe, are a key example of health and social care transformation as part of the £100 million spend, and that will help provide more care closer to people's homes and hopefully improve access times.



Evidence suggests that this approach will see patient issues resolved more quickly, for instance by reducing the need for referrals and appointments elsewhere. We believe that it will also ease demand pressures on hospitals. The approach will also see practice teams supported to identify opportunities for early intervention and patients will be supported in managing long-term conditions and dealing with lifestyle issues that clearly can impact on their health.

Health and social care trusts are currently working with GP federations to start the recruitment process for these new roles, with the new services expected to be up and running in the coming months in Derry and also in Down, which I am sure will be music to your ears. We are expecting to create in the region of 200 new posts to support this initiative, and in fact Down GP Federation, which covers around 75,000 patients and includes the areas of Saintfield, Crossgar, Killyleagh, Strangford, Downpatrick, Ardglass, Ballynahinch and Newcastle. We are looking forward to this next phase with a planned, province-wide roll-out. That will begin with west Belfast in the coming months.

Is there anything more to add to that?

Dr McCarthy: On just a very general point, Jim, you mentioned the potential role of nursing in out-of-hours. Across all areas, not only in primary care, we are looking at skill mix. We have very expert staff working across AHP specialities, pharmacy and nursing, and many of them are taking on extended roles. Everything we are doing to expand that in acute services, endoscopy nurses, for example, within cancer services, nurse and pharmacy prescribers, and indeed within primary care, potentially including out-of-hours, is a positive measure but it is all based, as Valerie has said, on a multidisciplinary approach. But getting the right skill mix will help manage demand and I think it contributes to a much more rewarding career for those professionals as well.

Q19 **Lady Hermon:** Thank you all very much for coming along this morning; it has been really interesting—fascinating. I have so many notes here. I will ask a few questions and then come back later with another few questions.

Paul, I have to say at the beginning that my sister is a pharmacist and it was music to my ears to hear you say that pharmacists have a real expertise, and they really do. My colleague Jim has mentioned the enormous value to a rural community, which Northern Ireland largely is, of community pharmacies. I listened very carefully to what you said and you praised pharmacies and I was pleased that you did, but can't we just have some reassurance that we are not going to lose community pharmacies?

Paul Cummings: Lose community pharmacies in rural areas?

Lady Hermon: Yes.



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Paul Cummings: I did say that we have potentially too many pharmacies—

Lady Hermon: I did hear those words but I don't want to hear—

Paul Cummings: —but that does not mean that we should be losing rural pharmacies.

Q20 **Lady Hermon:** That comes down to the definition of rural pharmacies.

Paul Cummings: There are many areas in Northern Ireland, as well you know, where you would find pharmacies on the opposite sides of the same street.

Lady Hermon: Competition is good.

Paul Cummings: Competition is good, yes.

Q21 **Lady Hermon:** Is that a hint that there is a plan?

Paul Cummings: No, I am not saying there is a plan. That is not something I am involved in. There is a negotiation with the Department. What we have to do is ensure that we get value for money and that everybody has appropriate access. Within the board we have a rural pharmacy support scheme and we give additional support to ensure that rural pharmacies continue to exist. Where they find it financially difficult, we have a range of additional support measures going into rural pharmacies. We absolutely understand the challenges that rural pharmacies have and ensure that they continue to have a model. There is absolutely no hidden agenda in my comments.

Q22 **Mr Goodwill:** Can I interrupt briefly, Chair? In my constituency we have pharmacies on the same street, next door to each other. Is that the situation in some parts of Northern Ireland, where there is a preponderance?

Paul Cummings: It is.

Q23 **Mr Goodwill:** Is that the point you are trying to make; that there could be some rationalisation?

Paul Cummings: Yes. My point is that the pharmacy model that we have costs roughly 12% more than the pharmacy model within England at present.

Q24 **Lady Hermon:** Well, with the greatest respect, there are large areas of rural Northern Ireland where in fact people are able to access a pharmacy at different times compared to their health centres, and that was one of the issues I was going to ask about. Are we thinking about that? In the two areas where we are going to do the pilots and increase the physiotherapy available at GP surgeries, is there any plan to make GP surgeries stay open longer?

Valerie Watts: We are looking at all of these options, and the recent work on GP federations has proved to be extremely helpful in coming up



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with a range of ideas for increasing opening times for GP surgeries. But, Lady Hermon, can I take you back to the pharmacy issue?

Lady Hermon: Yes, of course. I am taking some encouraging notes.

Valerie Watts: I think it would be unfair for us to not declare to the Committee today that there is very much an ongoing pressure in relation to medicines management and optimisation of the prescribing of medicines in the health and social care system in Northern Ireland.

Lady Hermon: And roughly translated, that means—

Valerie Watts: The Department of Health has set out a range of quality standards associated with its medicines optimisation quality framework and it is expected that services will be commissioned to take this forward in 2018-19. Perhaps Paul could dig a little deeper and explain a little bit more of the detail around some of the actual savings that are required as part of that agenda.

Q25 **Lady Hermon:** Rather than savings, I would like to hear that community pharmacies, indeed all pharmacies, whether there are two or three in a town or whatever, with the range of services that they can provide—that instead of queuing up and putting pressure on A&E and increasing waiting lists at local hospitals, people could go to their local pharmacy, where they have great confidence. Some of these pharmacies have been there for years and people have general and great confidence in them. It would shorten waiting lists at hospitals if the range of services were to be increased in community pharmacies.

Paul Cummings: We want exactly the same thing. The issue is around the funding envelope that would be required in order to achieve that. That is the issue of debate.

Q26 **Lady Hermon:** Right, so it is the budget that was taken through and that we are having this inquiry about. Were you surprised that in the budget that was taken through here by the Secretary of State there was not a greater allocation to pharmacies and the provision of their services, and expanding those, in the budget that was approved?

Paul Cummings: The budget that was approved did not have that level of detail. The budget that we were allocated has a very high level, so I got an additional £207 million. It was not at the level of delegation below. It was not split below that.

Q27 **Lady Hermon:** So you do not need a Health Minister to increase the range of services made available through community pharmacies.

Paul Cummings: At present, the level of funding did not allow us to increase our services at all. We can go into the detail, but we went into this year with a significant deficit because we are relying on, and have relied on, increasing mid-year and end-year monitoring rounds. Our system went into this current financial year in deficit because we required £140 million of non-recurrent funding last year through the monitoring



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round, just to break even. The £207 million was set against an opening deficit of £236 million. We are not in a position to procure extra services in the current financial year. We are just about standing still and meeting inescapable pressures, some demography, a bit of NICE drugs. We are extremely challenged financially and service development is not something we have been able to pursue in the current year.

Valerie Watts: Notwithstanding all of that, we are having in-depth conversations between representatives of the Health and Social Care Board and our pharmaceutical colleagues, particularly on the range of extra services that community pharmacies could provide to the public at large. We very much welcome those discussions. It is just a case of finding a way that we can perhaps fund some of those developments.

Paul Cummings: As I said, the transformation fund is one area we are examining with our pharmaceutical colleagues as to how we can explore our joint goals.

Lady Hermon: Good, because the confidence and supply arrangement has earmarked a large portion of funding to health, but you gave evidence to us earlier when you said that 1,200 new staff have to be recruited. I have written down here, "That's a challenge." You are struggling to spend money that was earmarked, because of the confidence and supply arrangement, but actually you are struggling to get money to fund pharmacies. That does not strike me as sensible.

Q28 **Kate Hoey:** Don't you have any flexibility to say, "We are going to use this—this is our transformation and we are going to transform by using community pharmacies more"?

Paul Cummings: The confidence and supply money is ring-fenced for the transformation projects only.

Q29 **Kate Hoey:** It is this word "transformation." Who has defined transformation? I absolutely agree with Lady Hermon that community pharmacies are so important; they have so much expertise. Surely that could be—

Paul Cummings: It is one of the areas—

Q30 **Kate Hoey:** So you could do it from the transformation fund.

Paul Cummings: But again it is non-recurrent funding, which has only two years of life. We are required to recurrently fund the pharmaceutical—

Q31 **Chair:** Has the Audit Office been interested in this particular matter? It seems to me that it is a question of how best to use public funds to achieve effect, and it is the kind of area where I would expect ultimately the National Audit Office to take a view. We have taken evidence from the Auditor General in Northern Ireland in Belfast and he is clearly very industrious—a very busy man doing what he can to keep the public finances under proper scrutiny. It seems to me that this is an area where



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he might wish to take an interest.

Paul Cummings: He may do. I am not aware of any interest to date. He did examine “Transforming Your Care” and did produce a report on TYC in the recent past. I am sure that this is an area he will examine once we start our expenditure to explore the value for money that we have achieved, but I do believe that the transformation funds are being spent appropriately and will achieve value for money.

Chair: Appropriateness and best effect is what we need to be focused on. I think perhaps we have identified an area for further exploration. Lady Hermon, are you done for the time being?

Lady Hermon: No, absolutely not.

Chair: You are just getting into your stride.

Q32 **Lady Hermon:** Before we move on to the next point on the next page, Valerie said she would sit on this committee and maybe others also sit on the committee, and it is chaired by the permanent secretary—I have taken that down—the transformation and implementation group. Can I have confirmation that one of the projects that group is looking at—you mentioned some of the projects but you did not specify—is spending the ring-fenced transformation money on community pharmacies? I know, because you have mentioned it, that it is limited to two years, I have got that point, but is that actively one of the projects being considered by the group chaired by the permanent secretary?

Paul Cummings: My understanding is that the discussions on the contract with pharmacists are exploring additional funding within the transformation fund for the next two years. That is my understanding but, just for clarity, I am not involved in that. It is, however, my understanding. It would be best to explore that with the Department of Health, which is involved in the contract negotiations between the pharmacists and itself.

Lady Hermon: That is very good of you. I am sure the permanent secretary will be delighted that you have volunteered.

Valerie Watts: Through you, Chair, I can write to you with the detail of that directly, after this meeting. But just for your information, and for Members’ information, in relation to the total list of transformation projects that we are funding through the £100 million of transformation moneys available for this year, the progress against some 80-odd projects is discussed at every TYC meeting.

Q33 **Lady Hermon:** Are those confidential, Valerie?

Paul Cummings: No, we have a list. We can provide you with the list.

Q34 **Lady Hermon:** Right. That will be very helpful. Can I come back to this? I am really concerned. There was evidence given, and we are aware of this, about the number of vacancies in core services. What numbers are we looking at? Is this one of the reasons why we have the long waiting



lists?

Valerie Watts: I believe that the latest figures in relation to vacancies across a workforce, don't forget, of over 65,000 employees in total—

Lady Hermon: Who do a tremendous job.

Valerie Watts: Who do a tremendous job, and we would like to pay tribute to those staff today because they continue to give of their best in extremely challenging and difficult circumstances. It was great to see many of those examples of good practice being highlighted in the recent NHS 70th birthday celebrations for Northern Ireland, so I would not want this to go unremarked upon today.

Across a workforce of about 65,000 people in total who work in health and social care services in Northern Ireland, I think we are currently looking at a total approximate number of vacancies—it changes almost from minute to minute, day to day—of about 1,800.ⁱ

Q35 **Lady Hermon:** Can you break those down between consultants, nursing staff and so on?

Valerie Watts: We would not have the detail of that with us today, Lady Hermon, but I am sure we could work on that.

However, the good news is that colleagues working across the HSE, led by their colleagues in the Department of Health, have developed a new workforce planning strategy that breaks down each of the challenges in relation to recruitment and retention of staff into workable pieces or projects. The intention here is to attract and retain the highest qualified, highest motivated, high-energy members of staff into health and social care, calling on our diaspora from all other parts of the world to come back to Northern Ireland, but I must outline to the panel that the pay differential for some of these grades of staff that exists for Northern Ireland health and social care staff in comparison with the other jurisdictions in England, Scotland and Wales, is proving to be very difficult for us. Paul might want to say a bit more about that.

Q36 **Lady Hermon:** That takes me very neatly to the question that actually is the topic. How are the NHS staff, who do a superb job in Northern Ireland, going to be awarded the pay increase that has been awarded to NHS staff in England, Scotland and Wales? How are we going to do that? It must be very demoralising not to have your pay increase.

Paul Cummings: It is, and for a couple of years now our staff have been paid 1% less than those in the rest of the UK, which has been a source of contention for staff. The Barnett consequential of the recent Agenda for Change announcement, which is a three-year deal, will pass to Northern Ireland but it will not be just given to Health, so we have to compete against other Departments. That is put into the general Northern Ireland pot and does not go straight to Health, so we have that challenge.



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The second challenge is that because we are health and social care, our social care staff, rightly, are on the Agenda for Change, and they get the same uplift. However, we do not get the Barnett consequential for social care because social care in England and Wales is on NJC terms and conditions and they did not receive a similar uplift. We have the challenge of where we will obtain the funding from for the social care staff that we would have to apply if we implement the recently agreed Agenda for Change. Within this budget, we do not have the available funds to do that, so that will require—

Q37 Lady Hermon: It is a funding issue? It is not the case that because we have no Health Minister to make a decision about the award of pay, because I have to say that is what we did think was the case.

Paul Cummings: There is a funding issue and then you would have to ask the permanent secretary whether he has the powers to implement a pay award. I am unable to answer that question. I don't know the answer to that question.

Lady Hermon: We have a long list of questions for the permanent secretary when he comes.

Chair: Can I interrupt you, Lady Hermon? I am going to pass to Robert Goodwill and then we will come back if there is time.

Lady Hermon: Yes, of course.

Q38 Mr Goodwill: I would like to ask a question about whether the lack of an Executive may be affecting some of the day-to-day decisions or some of the policy decisions you may have to make. You have mentioned already advice from the National Institute for Health and Care Excellence and drugs that may become available. There is that pressure; there are budgeting pressures. There are a number of specific areas, however, certainly here in England, where there is a lot of political input into some of these decisions. I am thinking of examples such as access to varicose vein surgery, which may have a cosmetic as well as a therapeutic element. There is bariatric surgery; in the land of the Ulster fry at what level of body mass index do you make that available? We have had very contentious issues about whether people stop smoking or lose weight before they have access to orthopaedic surgery. There is the number of cycles of fertility treatment, which has real political input. Lastly, which I think you referred to, there are some of the life-extending cancer drugs, which can be very expensive and in some cases advice from NICE can be overruled by politicians.

In cases like those, are you able to make those sorts of decisions based on budgetary and health advice or are you now feeling a little bit that the automatic pilot cannot take account of this particular turbulence that you may fly through without Ministers there to make those decisions?

Dr McCarthy: If I may respond to that first, I suppose there are a couple of things to say. One is with regard to arrangements with NICE. We have had formal arrangements going back to 2006 and there is an agreement



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that we will, subject to departmental endorsement about legislative and equality issues, accept the NICE recommendations for all drugs appraised and recommended as routinely commissioned under their technology appraisals. That has been in place for quite some time and that extant policy continues to apply to those drugs where it is for routine use and they have been appraised and recommended. There are other groups of NICE drugs where it is a little bit more complex, but that extant position remains.

We have had a longstanding position with regard to the Cancer Drugs Fund. Northern Ireland did not participate in the Cancer Drugs Fund and Northern Ireland still does not participate in a Cancer Drugs Fund because, again, the extant ministerial position remains the case.

Normal business does apply with regard to the vast majority of drugs recommended by NICE and we have for many years, as soon as the documentation goes out from NICE, made those drugs available from day one. We ensure that there is early access. For at least some period of time, we may indeed have been giving people in Northern Ireland earlier access than elsewhere because we act from day one. We do that even where there are infrastructure issues that we need to work on, additional pharmacy and nursing staff or whatever particular aspects apply to a specific drug. We will endeavour to make the drug available from day one on what we call a cost-per-case basis. We are monitoring it but we are making it available while we are building the service that may be needed in order to administer the drug to the cohort of patients. I do think that is more or less normal business, as it has been for many years.

Q39 Mr Goodwill: What about the other examples, which can be very politically charged?

Dr McCarthy: With regard to the areas where there is more of a challenge in making these available, with the Cancer Drugs Fund we know we have had requests and I know there has been correspondence—I have seen some of the correspondence—requesting that we make those drugs available, but the extant ministerial position at this point is that we do not participate in the Cancer Drugs Fund. That is an issue that would require a ministerial decision.

On other areas, and you mentioned a number—orthopaedics, varicose veins and bariatric surgery, which are all really important—we have developed an effective use of resources paper that looks at exactly what NHS England looked at, which is whether we were maximising the benefit of procedures and maximising the cost-effectiveness; in other words doing things that add value and not doing procedures that do not add value. We would be recommending for varicose veins for the purposes of sorting out pain or bleeding of the veins, but it is not as cost-effective if it is for what I loosely call cosmetic or appearances reasons.

We have a paper in process at the moment, which is almost in its final stages—currently subject to a detailed equality assessment, in line with



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our legislative responsibilities—and that would need to be considered by the Department and by a Minister, presumably, before going out for consultation. A very real-life issue at the moment is that we might expect that that could potentially be delayed if it was considered that a Minister needed to see and sign off on that because of the likely controversy, as I think Paul has indicated. For things where we are expanding and developing services, there is not a contentious issue. Things where we might be consolidating or appearing to restrict, even if the reason is a signed clinical reason, have the scope for a greater degree of public and media controversy and we would expect the Department and the Minister to approve those before being issued. There are some things where they may not progress to consultation as quickly.

Q40 Mr Goodwill: You could be in limbo until you have a functioning Executive or another ministerial decision-making process?

Dr McCarthy: That would be a potential outcome, yes, and I think the recent legal case has probably contributed to the informed decision making in that regard.

Q41 Chair: Is there a bow wave of decisions of this sort that are going to have to be made by the incoming Minister when he or she is appointed? We speak of limbo; we speak of things being avoided in terms of controversy. That implies that there will be a backlog of decisions that will have to be made from day one of the new Minister coming into office.

Valerie Watts: Chair, I think the inevitable answer to that is yes. However, it would be more for the colleagues from the Department of Health to give you some indication of the level of the decision making that would be required by any incoming Minister.

Q42 Chair: Would it be true to say that decisions being made are more permissive than they otherwise might be? I understand fully your desire not to be controversial, and it is a little bit like the point about closing things down, which is deeply controversial. As we all know as constituency MPs, it would be easier and less controversial to permit a particular treatment than perhaps to deny it, which would cause people potentially to do an incinerator-type thing and take a matter to judicial review, which is something you would want to avoid.

Dr McCarthy: I think that is a fair comment. We tend to have pretty clear policy advice on the kinds of things where we would be consulting, and that tends to apply to anything where there would be a significant service change. Arguably that could be expanding the permissive element, and certainly anything where there is a perception that we are restricting or consolidating, or indeed changing pathways in terms of how far people may have to travel. We abide by that policy on consultation and I think that we would probably consult with our local communities on things that perhaps may not necessarily be consulted on in mainland GB. We do consult on things. Part of that is about the local engagement and understanding what the local community really wants, so there is a real



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benefit in that. That will apply to significant things where it might be permissive but it might also represent some degree of change or alteration from the extant position.

Mr Goodwill: The community may decide that it does want people who smoke 40 cigarettes a day to have access to surgery, but that may not be what the doctors say. That is sometimes where politicians get involved but, as you have no politicians to get involved, at that level anyway, you are still in limbo, as the Chair has just said.

Q43 **Kate Hoey:** It is very good that Northern Ireland is leading the way in integrating health and social care. We can all learn from that.

I am still not clear. I would love each of you to give me one single example. If the Minister was sitting here, and had complete power to do anything about what is being held back at the moment, could each of you give me your priority? Dr Mairs, you have not had a lot to say. What are you prevented from doing at the moment because there is no Minister? Tell me the most important priority you would have, each of you.

Dr Mairs: Certainly I can tell you one thing. One of the issues that we have in Northern Ireland is a high suicide rate—as you probably know, it is higher than in England—and we do have our Protect Life 2 strategy, which would probably have to await a ministerial decision before being published and going ahead. That is one example.

Q44 **Kate Hoey:** If there was a Minister, would the Minister say yes to that?

Dr Mairs: Yes.

Q45 **Kate Hoey:** That was agreed almost before the Assembly stopped?

Dr Mairs: Yes.

Kate Hoey: Right, so that is one. Thank you.

Dr McCarthy: Perhaps this is not the most important one, but it is just immediate because we have been informed about it in the last few days. We have a paper written and ready for consultation on the type of surgery that people undergoing gender reassignment would have as normal routine commissioning—

Kate Hoey: Do you think that is a priority?

Dr McCarthy: —and that something that was done in GB—just last year, I think, there was a consultation—and that will, we understand, need to await a ministerial decision.

Valerie Watts: My point would be in relation to truly strategic financial planning. Clearly the financial outlook for 2018-19 and beyond, as we have already outlined, is extremely and increasingly constrained, particularly in relation to revenue funding. My ask of a Minister would be that we no longer just set the budget for health and social care on a year-by-year basis but that that would be pushed to try to establish



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budgets for health and social care that take a longer outlook, perhaps over a three-to-five-year period, if that was possible. We need to be not limping along from year to year, just hearing what we are getting to provide health and social care services sometimes somewhat late in the day. We need to be forward planning and planning over longer periods of time.

Q46 **Kate Hoey:** When you had a Minister, that did not happen?

Valerie Watts: No.

Paul Cummings: Mine would be that we have a Minister's view on the review of adult social care, the part of the paper that challenged us about how we are delivering adult social care at present and the recommendations of that have not been before a Minister. I would like to get a Minister's view on how we are going to deliver—

Q47 **Kate Hoey:** Will you be ready with your own suggestion for a Minister to approve or not approve?

Paul Cummings: We are, and there are recommendations in that report. There are groups working on that, but I think it would be much better if we had a Minister leading that strategy.

Q48 **Kate Hoey:** I wonder whether the general public in Northern Ireland have missed having a Minister in the Health Department. That is not to say that they do not worry about all the things that we have talked about, but perhaps they do not really see why a Minister is going to make much difference.

Finally, because we are short of time, this whole transformation terminology is a kind of catch-all, isn't it, for bringing in anything that you want to do or try to do? Is it part of that transformation to have fewer managers who tick boxes at the top and more people at the bottom?

Valerie Watts: We have endless discussions at the transformation implementation group about staffing issues, but the overarching priority is to ensure that we have the right people in the right place with the right skills delivering the right outcomes for the people we serve in Northern Ireland. There is a never-ending and ongoing process of managerial inspection, of ensuring that we have the right people in the right places to deliver the right things at the right times to right standards and quality standard, ensuring at all times the safety of patients and indeed trying to raise the quality of care through the ongoing introduction of new quality initiatives.

Q49 **Kate Hoey:** The extra staff you need, that you mentioned earlier, are going to be real people doing—

Valerie Watts: Very much frontline staff

Kate Hoey: At the sharp end, doing jobs?



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Valerie Watts: Yes.

Q50 **Chair:** Can I ask a little bit about core budget, very briefly? We discussed, in connection with pharmacy, how there are obviously pressures around that, and you have identified that spend in Northern Ireland on community pharmacy is in excess of that in Great Britain. That does not necessarily mean to say that is a bad thing, but nevertheless clearly your building blocks through the budget that you put up to Ministers is comprised, presumably at a fairly granular level, of items such as pharmacy and your expectations as to what is required in order to finance properly the health and social care budget in Northern Ireland. To what extent do you think that constructed budget that you put up to Ministers is then owned by Ministers; in other words that they have endorsed those building blocks? What I am really trying to drive at is the granularity at which a decision has ultimately been made by Ministers who sign off that budget. I am not clear in my mind what your sense of that ownership is.

Paul Cummings: I think inevitably we tend to focus on the extra bit or, as I call it, the icing on the cake. We focus on what are we going to do differently from last year. Within Northern Ireland we spent £5 billion on health and social care; we focus on the extra £200 million, on the £100 million and the transformation bit, and we do not see if we can reconstruct the cake. We spend roughly £900 million on primary care, 42% on acute hospital care and 7% on mental health. Changing that makeup is extremely challenging, so we focus on, "We have £200 million extra this year, so how are we going to divide that up?", rather than ensuring that we look at the entire cake.

Q51 **Chair:** But you said that the core budget is under pressure.

Paul Cummings: It is.

Q52 **Chair:** Who is the public to call to account for that because some Minister somewhere has approved that budget and indeed presented that budget? That is a slightly rhetorical question.

Valerie Watts: I suppose what happened this year, Chair, was that the Secretary of State for Northern Ireland announced the budget position for 2018-19 for all Northern Ireland Departments, and that happened back on 8 March this year. While that budget provided a measure of protection for health and social care and represented an increase of 2.6% compared to the comparable actual funding levels for 2017-18, the total cost pressures are more likely to be between 5% and 6% per annum on the budget and, therefore, clearly difficult challenges remain in meeting the demand to try to maintain existing services. But much work has been done between the Department of Health and colleagues in the board and the trusts to try to work our way through how we maintain existing levels of service, as well as looking at how we spend the transformation money in the right way to bring about sustainable change.

Chair: I think that answers the question. I will not labour the point. I did



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interrupt Lady Hermon. I am going to ask her very briefly to put her final question.

Q53 **Lady Hermon:** You were very gracious in interrupting me, so thank you very much indeed.

Dr Mairs, I am really alarmed to know that there is a strategy to deal with suicide in Northern Ireland but it has not gone ahead because we do not have a Minister.

Dr Mairs: Well, we do have an extant strategy and we do have clear plans for developing our services in relation to suicide prevention, because in the past, of course, most of the focus was on dealing with the aftermath of suicide.

Q54 **Lady Hermon:** That is traumatic and dreadful for the family, friends and the community. It is a dreadful thing to happen and we have far too high a level of suicide in Northern Ireland. You are cautious and you do not want to be judicially reviewed. You are doing things that are good for the community, but if you were cutting back there might be a reaction and you are not pursuing that. However, I would have thought that there could not be anybody who could object to any policy that reduced the number of suicides in Northern Ireland.

Dr Mairs: I am really glad that you have brought it up, because we are doing quite a bit in relation to suicide and we have done a lot in Northern Ireland and done things in Northern Ireland that have not maybe been done elsewhere.

Q55 **Lady Hermon:** Why has that not reduced our numbers?

Dr Mairs: I think we have different characteristics within the populations in Northern Ireland. We have had a higher rate of suicide and we know we have about a 25% higher rate of mental health issues in Northern Ireland than elsewhere in the UK. Part of that relates to the legacy of the Troubles, intergenerational trauma, ongoing violence in some areas, deprivation and the impact of the economy on people living in deprived circumstances, for example the introduction of new synthetic drugs. There is a wide range of reasons why we have higher suicide rates in Northern Ireland.

Q56 **Lady Hermon:** And we have a policy to reduce the numbers.

Dr Mairs: We do have a policy to reduce that, and whereas in the past a lot of the focus was on what happened in the aftermath of a suicide, we have a lot of programmes and policies in place to provide information, education, training and learning to the statutory, voluntary and other sectors in relation to identifying suicidal ideation. We have, combined with the Republic of Ireland, a self-harm register. Our suicide rate is somewhere in the region of 16 per 100,000, but our self-harm rate—we know this because of our self-harm register—is about 345 per 100,000. A lot of people self-harm, and for some of those people we have a self-harm identification programme that can identify who might go on to



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develop suicidal ideation, so that we can intervene at an early stage. We have been putting place a self-harm intervention programme—the SHIP programme—even in the absence of having a policy.

Q57 Lady Hermon: Good. I am glad to hear it. Which bit is sitting on the shelf?

Chair: Lady Hermon, if I may I am going to draw the session to a close. I know we are about to lose one of our members, which means we will not be quorate.

Lady Hermon: Well, our member is just going to sit for one more because lives are at stake. I want to know which bit is still sitting on the shelf, that has not been done. Could you go back from this Committee session and impress upon the permanent secretary, who has done a very good job, that we need to take every measure possible to reduce the number of suicides in Northern Ireland? That is a very clear message.

Dr Mairs: Could I reassure you, Lady Hermon, that we are and that there are a number of other programmes, including projects that we have within the transformation funding, that are looking at more early intervention, suicide prevention efforts?

Lady Hermon: The sooner the better.

Dr Mairs: It is not as though there is nothing happening. I really do want to impress that on you.

Q58 Chair: Thank you very much for that. That is a good point at which to leave. Thank you for all the efforts that you are making, in very difficult circumstances, in Northern Ireland. I think you will have gathered from the probing we have given you this morning that we are very exercised about the failure of the Executive at Stormont and the impact that is having on day-to-day lives in Northern Ireland. You have helped our thinking in this matter greatly. Once again, our huge admiration to you and your people for doing everything that you can to ensure that the current impasse does not impact as gravely as it otherwise might on the lives of people in Northern Ireland. Thank you very much indeed for being with us today.

Valerie Watts: Thank you for the opportunity to give oral evidence to the Committee this morning.

ⁱ Correction: [As of the 31st March 2018, there were a total of 5,654 both permanent and temporary vacancies across the HSC in Northern Ireland](#)