

Northern Ireland Affairs Committee

Oral evidence: [Funding priorities for the 2018-19 Budget: Health](#), HC 1147

Wednesday 16 January 2019

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

Questions 312 - 390

Witnesses

I: Richard Pengelly, Permanent Secretary, Department of Health (NI); Jackie Johnston, Deputy Secretary of Healthcare Policy, Department of Health (NI).

Examination of Witnesses

Witnesses: Richard Pengelly and Jackie Johnston.

Q312 Chair: Mr Pengelly and Mr Johnston, welcome. It is very good to see you here. Thank you for coming to meet us today. Obviously we meet at interesting times politically in this place, but at the end of the day what matters to most of our constituents are important public services like healthcare. It is healthcare in Northern Ireland that we are particularly focused on this morning. I wonder whether I can invite you to introduce yourselves briefly before we crack on with questions.

Richard Pengelly: I am Richard Pengelly. I am Permanent Secretary of the Department of Health and chief executive of Health and Social Care in Northern Ireland. Also, I do not know whether this is necessary but, for full disclosure, my wife is a Member of the House, just to place that on the record.

Jackie Johnston: I am Jackie Johnston. I am deputy secretary with responsibility for healthcare policy within the Department of Health.

Q313 Chair: Mr Pengelly, can I start with the response you sent to our correspondence on 20 November, for which many thanks? Clearly, cancer and cancer strategy in Northern Ireland is a particular concern given outcomes in Northern Ireland—targets for cancer in Northern Ireland are consistently not being met and things like screening might be described as somewhat antique in comparison with practice elsewhere. I know you are intent on improving the situation. I wonder whether I could draw your attention to the remarks you made about the cancer strategy in your letter. You said you would be looking to publish a new cancer strategy by early 2019. Perhaps this might be an opportunity to provide an update as to where you are on that.

Richard Pengelly: We will not be publishing a new strategy. We will be publishing terms of reference for the work to develop that strategy. That will be a substantive piece of work, which will take some time. One of the early phases for us is to develop the terms of reference for that piece of work and, in particular, to engage with a range of stakeholders across the community, in particular the cancer charities, with which we have a strong engagement. Jackie, can you comment on the specifics of where we are?

Jackie Johnston: We are currently scoping out potential draft terms of reference, which we should have completed in the next week or so. We then want to engage with the cancer charities to share those draft terms of reference. We are also looking at the membership of a potential steering committee, which we want to chair with the cancer charities. The aim is to have all of that work finalised during February and then, subject to Richard agreeing it, we would then publish what the terms of reference



would be, what the steering group would comprise and the timescale for completing it.

We will be looking at best practice elsewhere in relation to the terms of reference. For example, there will be a considerable focus on the anticipated growth in cancer incidence, which we are anticipating over the next number of years due to the ageing population, looking at what we can do in terms of preventative measures looking at the experience of cancer patients and trying to improve that as well.

- Q314 **Chair:** To what extent is the Northern Ireland (Executive Formation and Exercise of Functions) Act we passed last year assisting you in that process? Where are the limitations? I appreciate that you cannot come up with a ministerially approved strategy at the drop of a hat. It sounds to me as if you are putting in the footings, as it were, to allow that to be ratified in due course. But I would like to know from you whether you feel that piece of legislation is enabling what you are doing at the moment and what limitations you are still experiencing. In particular, I would not want there to be any impression of simply kicking the can down the road and awaiting an Executive, which of course may not happen for some considerable time.

Richard Pengelly: First, the legislation has been extremely helpful both on this issue and on a range of issues in terms of our ability to take decisions. On the limitations—this is an issue we will come to when we develop the strategy—taking a decision to approve and implement a new cancer strategy in one sense is easy, in and of itself. The difficulties lie in how we fund that and, particularly, how we fund it within a finite budget. The reality is that, where additional costs would lie and go alongside the implementation of that strategy, a fixed budget will mean that activity elsewhere will have to be scaled back.

That is where the more difficult decisions lie. When the strategy evolves, that is an issue that we will look at in the context of the financial position at the time. That is true of a range of initiatives we are taking forward. The difficult issues do not lie with the issue; it is the consequences of moving forward on a specific issue.

- Q315 **Chair:** Mr Johnston, you mentioned timescale. That is very important, particularly in the context of dispelling the impression that this is kicking the can down the road, awaiting ministerial decision-making in due course. What timescale do you anticipate for the programme of work that you and Richard have just announced?

Jackie Johnston: Our ambition is to have the working completed in a year. We want to publicly consult on the recommendations and hopefully have that ready for an incoming Minister to make a decision on in terms of implementation and resources to back up whatever proposals emerge.

We are moving forward in other ways. We have an improvement project underway, which is on transformation funding. It is already tackling some



issues in oncology services. For example, in the work coming out of that, there is the potential to reduce hospital visits by 50% through telephone assessment before each cycle of treatment. There could potentially be a considerable reduction in consultant time by having non-medical prescribing done, for example, by specialist nurses coming in to carry it out, which would release consultant time to focus on more complex cases.

We are hoping to prototype that work in the year ahead from April. That will run alongside the development of a wider strategy looking at what the need is over the next 10 years or so. There is improvement work ongoing as well as the development of a new strategy. It is not as if we are not moving forward in other areas.

- Q316 **Chair:** Strategies are great, but they are only of any use if they produce positive outcomes. Let me pluck one out of the air. Bowel cancer screening in Northern Ireland is probably behind the curve. When would you anticipate FIT screening coming online in Northern Ireland? Does that require a piece of ministerial decision-making? If so, in the absence of an Executive, what happens if we do not have an Executive set up for many, many months? Who is going to make that decision? Do you feel you are empowered to do so under the legislation passed last year?

Richard Pengelly: I have looked into this in some detail, and the short answer is yes. I feel I can make that decision. The preparatory work is happening at the moment, but I want to defer the actual decision-making process until we get a budget allocation for 2019-20 and we can consider the financial implications. In terms of the power to take the decision to move to that form of testing, I am confident that the legislation allows me to do that.

- Q317 **Chair:** That news is really good to know. Can I then, on the subject of budgets, draw you a little bit on something else that featured in your letter of November last year? That is cancer drug funding. Some progress has been made on that in Northern Ireland, and I am very pleased about that, but you assured us in your letter that the money would not come off transformation funding, for example. I was left a little unclear as to where the extra costs would be borne. Are you able to shed any light on that?

Richard Pengelly: The difficulty is in actually getting a sense of what the additional costs are. This is a reform of what we call the IFR, the individual funding request approach. Currently, we spend about £2 million per annum on that. We think there will be an increase in that. It is a relatively small amount, and we need granularity on it. Given the pressing nature of that, in the context of our £5 billion budget we can manage that within the overall churn throughout the year. Given previous ministerial commitments on this point, and there had been a lot of ministerial engagement, there is a pressing need to move the position. We need to move quickly to do that. I am confident that I can manage



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the costs, which are not that significant, within the churn as we move forward.

Q318 **Chair:** That surprises me, because the whole point of what was going on last year was to improve access to cancer drugs. I would expect that to be really rather expensive. Knowing the costs of some of these medicines, I would have thought that would be a significant budgetary item. You are telling me that it is something you can manage in the round.

Richard Pengelly: Yes, in the narrow confines of the IFR process. The IFR process is not a step towards full commissioning of the drugs, and the cost lies in the full commissioning of the drugs, which has always been the case. What we are looking at here is making specific new emerging drugs available to patients who have a set of conditions that set them apart from the general patient cohort. Once we move into cohorts of patients, it becomes a normal commissioning decision, which is part of parcel of the Health and Social Care Board's activities.

Q319 **Chair:** Okay, so when will you have a better idea as to what the cost of this will be?

Richard Pengelly: It will be an evolving position. The key date for us is 28 February. That is when our regional scrutiny committee will meet for the first time.

Jackie Johnston: We estimate that for the entire individual funding request budget the initial uplift will probably be about £500,000. That will then increase to approximately £2 million recurrently, but it will start off next year around £500,000.

Q320 **Chair:** All right, so you have some idea of what you think this is going to cost.

Richard Pengelly: But I would not like to bet the house on their accuracy. They are broad-brush estimates.

Q321 **Chair:** I am slightly concerned about that, because I suspect the cost will be greater rather than less. I am still troubled as to where that is going to come from.

Richard Pengelly: That estimate is based on existing activity through the Cancer Drugs Fund in GB and looking at population share.

Q322 **Kate Hoey:** Has the confidence and supply agreement, which brought some extra money to Northern Ireland for health, made a difference in that area?

Richard Pengelly: The funding we received in 2018-19 has made a difference across the whole range of health and social care. At the time we estimated that the budget settlement we received was about £160 million short. Through in-year monitoring, some efficiency savings and a change in spending patterns, we are on track to break even this year. In



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terms of general running costs, within that there is about £70 million of confidence and supply money, as distinct from the £100 million of transformation funding.

Q323 **Kate Hoey:** Specifically for health, you mean.

Richard Pengelly: Yes, so we would have been £70 million short. That has gone in to support all areas. It has not been specifically allocated to particular strands of spend. If we took £70 million out, it would have huge adverse implications.

Q324 **Ian Paisley:** When was the last time your Department broke even?

Richard Pengelly: Pick any year. There was one year it overspent. I do not know whether it is appropriate to say that it was before my time.

Ian Paisley: But it was.

Richard Pengelly: It is important that we in the health and social care sector acknowledge that this has come at a cost to other Departments. Our colleagues in the Department of Finance have worked very closely with us to support our additional case for funding. I am conscious that this means less funding is available for other Departments. As important as health and social care is, a whole range of fundamentally important public services take place in other Departments. With good support, we are managing to break even every year, but the big cost in that is our position in terms of waiting times, as you will be very aware.

Chair: We have quite a lot of interest in this material, as there are lots of Members here today. That means we are going to be very disciplined with our questions. Can we have brief questions, please? If I may, I would appeal for brief answers.

Q325 **Jim Shannon:** Richard, it is nice to see you here. Thank you for your regular correspondence with me probably every week or on numerous occasions. Thank you for your comprehensive replies as well.

There are many issues, and I am very conscious that the Chair has set us a challenge of trying to do this succinctly, which will be perhaps most difficult for me particularly. In relation to pharmacies, they have been a big ongoing issue for us. I know you set some £9 million of extra moneys aside for pharmacies, and that helped greatly. But the pharmacies have been on to me, and probably on to us all as elected MPs for Northern Ireland, to express their concern about the shortfall.

In my discussions with your Department, I understand that there has been some coming together of that. Can you perhaps just update us on that? I will do two or three questions at once. I have a number of questions, but I will do them in two blocks, if that is okay. The second one is to do with the oral health strategy. We have not had a review of that for 10 years and the British Dental Association in Northern Ireland has been on to me, asking for that strategy for oral and dental health to be done. There has been a nodding that it will be done, but can you just



confirm that?

On the Chairman's issue of a cancer strategy, I am very aware of the four cancers that are most prevalent in Northern Ireland: prostate, lung, breast and bowel. In terms of breast cancer, I would just say that a very good friend of our family's went through a mastectomy last Friday and will then have reconstructive surgery. I am conscious of those four cancers. In the last cancer strategy, none of the three cancer waiting time targets have been achieved. Again, perhaps you can just tell us what is happening on those three things.

Richard Pengelly: In terms of pharmacy, first, it would be remiss of me not to publicly acknowledge, at the start, the fantastic work that has been done on community pharmacy. It is a fantastic resource for the community and for the health and social care system, and it is of fundamental importance. We have had ongoing dialogue. There are certainly financial pressures in community pharmacy. No one would dispute that. The additional funding we announced a month or two ago has helped.

I received the latest update yesterday on the dialogue between my colleagues and the colleagues from community pharmacy. If I had to characterise it, I would say we are nearly there. There is good will on both sides and, importantly, the good will on both sides is being acknowledged by both parties. I sincerely hope we can get through that. Community pharmacy is too important to me and to the community to risk damaging it. We are nearly there. With one final push, we can reach a position.

In the context of the question about confidence and supply, part of that deal is about trying to make available just over £4 million of transformation funding. There is a lot of untapped potential in community pharmacy. We could better utilise it. There is an amazing skill set there. We have had campaigns in the past that try to redirect the community towards pharmacy rather than the GP. As I say, there is untapped potential there. With a fair wind, we are getting there on community pharmacy, and our work will continue.

In terms of oral health, I am aware of the BDA view that the 2007 strategy needs to be refreshed. In response to correspondence from the chair of the BDA—I responded last week—I have a meeting scheduled with him in the coming weeks. I want to get more granularity on their view. The position I am getting from my own chief dental officer is that we have made huge strides. A lot of what is in that strategy remains fit for purpose, but there are some issues we need to look at. I want to await that conversation with the chair of the BDA, take that forward on a partnership basis with him and build on the improvements we have made in recent years.

In terms of cancer, we have covered the strategic approach. There is a whole range of issues in the operational bit. The two big issues are



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workforce issues: availability of workforce and configuration. We have quite a fractured approach. We are doing a piece of work in particular on the assessment services for breast.

Jackie Johnston: In terms of breast assessment, we are aiming to go out for public consultation next month on proposals to reduce the number of centres in which we are currently carrying out breast assessment for patients who have symptomatic indications. About 2,500 patients annually come through screening and direct referral. Timeliness of access is critical for them. As Richard says, at the moment our workforce is spread across five centres, which means that we have resilience issues. The proposal would be to reduce that to a smaller number of centres and introduce regional referral rather than trust referral, so those patients have a more efficient referral pathway. The overall breast screening programme would not change. It would still be available across the five trusts.

That is one example of where we are trying to deal with those resilience issues, but overall we have a capacity problem in terms of cancer treatment. That is something we aim to address over the long term, but certainly breast assessment is what we want to start with.

Q326 **Jim Shannon:** One in two people will have cancer in Northern Ireland. Seven out of 10 of those people will survive and three out of 10 will not. If at all possible, 100% cancer eradication is a goal worth trying to achieve. We are aiming towards making sure those three out of 10 can survive. In terms of the oral and dental strategy, you know and we all know, as Members of Parliament for Northern Ireland, we have the worst oral and dental hygiene and decay in the whole of the United Kingdom; therefore, it is very important. On the pharmacy I am very encouraged by what you have said about how we are coming to a conclusion. Well done to everyone who has made that happen.

The other question I have—this is my conclusion—is about access to the drugs. I share the Chairman's question over whether the money set aside for cancer drugs may not be enough. The reason I ask that question is because some of my constituents have come to me and asked me about access to the asthma drugs in particular. In my correspondence with your Department, you indicated that the Cancer Drugs Fund was not exclusively for cancer drugs, which backs up the comment the Chair made. How will the moneys be there to ensure access to cancer drugs, but also other drugs like asthma drugs, for instance? You will be aware of issues around access to drugs for other lung-related diseases as well in Northern Ireland. We have fought those campaigns, for instance on cystic fibrosis.

The last question is in relation to the diabetes strategy. I declare an interest as a type 2 diabetic. I have been for some 14 years. But I just want to ask a question, because we have very high levels of type 2 in comparison to the rest of the United Kingdom. I think we are even ahead of Scotland and certainly ahead of England and Wales. We also have the



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highest levels of type 1 diabetics among children. Again, they are greater than the rest of the United Kingdom. Richard, I write to you regularly on the particular subject of diabetes, diabetic pumps and access to them. Some of my constituents' parents pay for pumps, and that is quite a challenge for them. I know I have written to you before about this, but there is an issue about how we address diabetes and access to insulin pumps for type 1 diabetic children. I attended an event yesterday to do with obesity, because the two are related, certainly partially if not entirely. Are we going to have an awareness programme to address that?

On the drugs issue, again, one thing has come into my mind, which I should have said earlier on. When patients are discharged from hospital, sometimes prescriptions are not available for them if they are discharged over a weekend. Those are my questions. That is my conclusion.

Richard Pengelly: I will try to go through these quickly, Chair. In terms of the cancer and asthma drugs, to be clear, although the changes to our IFR process were in many ways prompted by the availability of the Cancer Drugs Fund in England, the changes we have made are not in any way restricted to cancer drugs. In response to the establishment of the Cancer Drugs Fund, NICE introduced a new categorisation of approvals. That is not restricted to cancer drugs; it is new and emerging drugs. Our changed position will apply to any and all new drugs coming on to the market.

Q327 **Jim Shannon:** Is the funding for all those new drugs there, potentially?

Richard Pengelly: It is something we will need to keep an eye on, but the IFR process is limited to very small patient numbers. Once it gets above a patient cohort, it becomes a commissioning decision. In terms of the specific changes to IFR, there are some issues of uncertainty around the exact quantum of that, but we will be able to manage it.

If I can pick up your other point about drugs and discharge, the current policy in Northern Ireland is that 28 days' medication is made available on discharge. The issue we have is that sometimes, for example, if a consultant decides a patient can be discharged on a Friday night, there is limited pharmacy availability on a Friday evening. There is a choice at that stage: do we hold on to the patient for another day or two until the pharmacy can supply 28 days of medication, or is it in the patient's best interest to let them get home tonight with lesser supply? That is a clinical call. Most people want to get home to their own bed as soon as they can, but I will certainly raise it with my colleagues at trust level to see whether there is anything else we can do to improve that.

In terms of diabetes, it is a huge issue for us. It is a big issue. We introduced the new diabetes strategic framework in the last year or so.

Jackie Johnston: Our first priority in that area is to introduce a new foot-colour programme to reduce the level of amputations in Northern Ireland arising from complications related to diabetes. We are also going to be targeting diabetes in pregnancy to provide enhanced care in that



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area. We are also providing enhanced care for diabetic patients who arrive on general wards to make sure their requirements are identified and provided for from the outset.

In the area of prevention in relation to public health messaging, we have developed, under the transformation funding, a new initiative working through primary care where we will be targeting, on a pilot basis, a number of individuals who have signs of potentially developing type 2. That will be a proactive lifestyle and diet programme introduced for those patients to offset the development of type 2. We have started quite a bit of work in the last year, following the publication of that strategy.

Q328 Jim Shannon: What about the issue of type 1 insulin pumps, Richard?

Richard Pengelly: Is that the FreeStyle Libre?

Jim Shannon: It is for young children in particular. I have a number of young children in my constituency who are type 1 diabetic, and we have an increasing number of them. This is about access to insulin pumps, but also access to the insulin itself. The parents have to pay for the insulin, because there is no access. Let us be honest: it is because of the numbers game. I understand you only have a certain amount of money set aside, but I have a number of constituents, honestly, who are pressed financially in relation to their income, but because their child depends on this they then have to buy some of the insulin and other stuff to look after the children themselves. To be fair, I have met with your officials about this matter, and they are aware of the issue. Because there are an increasing number of type 1 diabetics, I am rather concerned about it. I would really appreciate some help in accessing funds for that, if possible.

Richard Pengelly: I was not aware of the issue of parents having to pay for insulin, but, with your permission, could I take that away and come back to you with the detail on that?

Jim Shannon: I am certainly more than happy to do so. I will send you some of the details. It might be helpful. Can I just say thank you very much for all the work you do as Permanent Secretary as well? It is much appreciated.

Richard Pengelly: Thank you.

Chair: If I can just pick up on your remarks about giving drugs out on a Friday, frankly, it is depressing. When I qualified in 1984, the same issues applied in getting people home. Because of a lack of drugs it was often impossible on a Friday. Here we are all these years later, and it is still causing people to spend more nights in hospital, which is against their wishes, clinically appropriate and extraordinarily costly. Across the UK, I really hope we can nail this one.

Q329 Lady Hermon: It is very good of the two of you to come over and give us evidence today. It has been very interesting indeed, and concerning as well. Before we talk about your preparations for a no-deal Brexit, which



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we will come to and we should come to, unfortunately, there are some key issues around pay rises. What progress has been made on the 3% pay rise for NHS staff in Northern Ireland?

Richard Pengelly: I would go back to the Chair's question about legislation. Utilising the powers available to me—I took the decision—we have made that pay award.

Q330 **Lady Hermon:** Did you make it in full?

Richard Pengelly: Yes, in full. We have replicated the pay rise that was put in place at a national level. There is a residual issue because some of the unions in Northern Ireland still aspire to complete pay parity with GB levels. But we replicated the increase that was put in place.

Q331 **Lady Hermon:** What percentage was the increase?

Richard Pengelly: It came to 2.97% of our total pay bill. It was the same model that applied in England. It was 3% at the top of the scale, a very substantial increase at the bottom of the scale and around a 1.5% increase to all points in between. But it mirrored the increase that was agreed at a national level. I took a decision to do that. The latest update I have received is that, with a fair wind, that will be in February pay. If not February pay, it will be in March pay.

Lady Hermon: That is this year.

Richard Pengelly: Yes.

Q332 **Lady Hermon:** Excellent, that sounds good. So we are having a good wind. With a good wind, lots of things are going to change. I was very struck by what you said. In reply to the Chair, you said the legislation had been "extremely helpful". You have given one example, which is the pay rise, and thank you for that. Could you give the Committee more examples of how it was extremely helpful?

Richard Pengelly: It has been helpful in terms of the additional funding that I made available for community pharmacy. There is the pay, as we have talked about. There was also the organ donation policy statement. Two issues we may come on to—although I have not taken a decision on them yet, I have had legal advice—are the Protect Life 2 suicide prevention strategy and HPV screening. Under the legislation, my assessment is now that I can take those decisions. Again, they have potentially significant resource implications, so I want to defer the absolute definitive point until we see the 2019-20 financial settlement, but it has enhanced my ability to take those decisions.

Q333 **Lady Hermon:** This is the new strategy to help prevent the increased incidence of suicide.

Richard Pengelly: Yes, when the chief medical officer was here it was covered quite extensively, but Michael and I have had some long conversations on that and our assessment is that we can proceed with



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that, subject to looking at the financial position when we get a 2019-20 financial settlement.

Q334 **Lady Hermon:** When are you expecting to know about that financial settlement?

Richard Pengelly: Those conversations are ongoing. I had a bilateral with colleagues from the Northern Ireland Office and the Treasury a day or two before Christmas. They are currently considering the issue. I would hope that within the coming weeks they will be able to settle on a financial outcome for us, to allow us to take forward the planning for 2019-20.

Q335 **Lady Hermon:** You have made a decision in your own head that you will implement the new strategy to prevent the increasing number of suicides in Northern Ireland.

Richard Pengelly: Yes.

Q336 **Lady Hermon:** That decision has been made with the caveat that the funding is there.

Richard Pengelly: Yes, subject to affordability.

Lady Hermon: That is very good news.

Richard Pengelly: But in terms of the key point, the ability to approve and implement the strategy, I am comfortable that I can do that and proceed.

Q337 **Lady Hermon:** That is very good. Could we have some good news—if we are going to have a good wind throughout the evidence that you are giving us today—for cystic fibrosis sufferers in Northern Ireland? There has been progress in Scotland.

Richard Pengelly: There has.

Lady Hermon: Could you confirm today please, for the families with children with cystic fibrosis—it is a dreadful condition—that Orkambi will be made available in due course in Northern Ireland? Can you make that commitment?

Richard Pengelly: I understand that the position has evolved in Scotland. Scotland does not use the NICE methodology that we use in Northern Ireland and England. I understand the manufacturer, Vertex, will be making a submission to the Scottish equivalent of NICE. In the meantime, I understand that arrangements have been made to make Orkambi available to patients in Scotland.

Q338 **Lady Hermon:** Could we do the same in Northern Ireland?

Richard Pengelly: We cannot get the details of the agreement there because it is commercial in confidence. But yesterday I formally asked the board to reach out to the manufacturer to start discussions to see



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whether we can possibly reach a similar arrangement for patients in Northern Ireland.

Q339 Lady Hermon: That is very encouraging news. I am delighted to hear that. I am really delighted indeed. Thank you. Can we have good news about the stroke strategy? It was supposed to be issued for public consultation in 2018. That has passed. We have turned a new page in the calendar; we are into a new year. When are we going to have the stroke strategy out for public consultation?

Jackie Johnston: The proposals for public consultation on stroke services will be out by March.

Lady Hermon: That is March of this year.

Jackie Johnston: Yes.

Q340 Lady Hermon: Why has it been delayed?

Jackie Johnston: It has been delayed largely because we have been looking at what the reconfiguration implications will be. The proposals will probably be to introduce two hyper-acute stroke units in Northern Ireland and then a number of smaller acute stroke units. We will really be looking at what the population distribution is and the evidence underpinning that so we make the right judgment on where those centres should be located. That is taking a while to progress. We have got through that work now, and we will be putting out the consultation document in March.

Q341 Lady Hermon: You said there would be two hyper-acute centres for stroke.

Jackie Johnston: Yes.

Lady Hermon: Presumably one will be west of the Bann. Maybe I am completely wrong on this. I am guessing one will be west of the Bann and then one will be in Belfast. Is that the case? Are you able to tell us?

Jackie Johnston: That would probably be a good indication, yes, in terms of population distribution. We might want to go to a phased introduction. Ultimately we might go to two centres but in a phased way, so we have additional centres in the initial period implementing the strategy and then reduce down to two. But Belfast and the west look the most likely areas.

Q342 Lady Hermon: Could you narrow it down even more than that?

Jackie Johnston: Why I am a bit reticent is because there are implications, then, in terms of making space available at those potential sites, because we would have to redistribute other services.

Q343 Lady Hermon: Okay, but that is encouraging. We are definitely going to see the strategy in March. If we do not, you will have a letter from the Chair asking to explain that.



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Jackie Johnston: You will have the consultation document, which sets out the proposals.

Q344 **Lady Hermon:** That is good. I am pleased that the legislation we passed has been so helpful to you, but in the continued absence, sadly, of a Health Minister, what are the major decisions that need ministerial approval but cannot be made in Northern Ireland even with the new legislation? What are the ones that worry you most when you go to bed at night?

Richard Pengelly: The thing that worries me most about health and social care in Northern Ireland is the outrageous waiting times for elective procedures. That is the issue that causes me the greatest concern.

Lady Hermon: Thank you. Yes, absolutely.

Richard Pengelly: In the context of a ministerial position, the reality is that we are more fortunate than any of my colleagues in other Departments, because in October 2016, a short few months before the collapse of the developed institutions, the Executive signed off on a cross-party basis the *Delivering Together* transformation strategy. It is that strategy that, in the medium-to-long term, will allow us to deal with that position. In strategic terms, I have a much greater sense of ministerial authority than many of my colleagues in other Departments. That is the blueprint for us in taking forward transformation. That gives me a lot of cover to progress things. In terms of the big transformation piece, we did the consultation on the configuration of services. Can you describe the outcome of that?

Jackie Johnston: Yes. Following the Bengoa process, Bengoa recommended new criteria that should be introduced to assess the viability of services in hospitals. We took that through draft consultation, but we have not been able to finalise it, because it will be a significant policy change. It was indicated as a need to consult on in *Delivering Together*, but the actual decision on introducing those new criteria will really be down to a new Minister to take.

Having said that, we have been able to make progress on taking forward, for example, the development of elective care day-case centres, which will be part of that reconfiguration. In December, we set up two pilots for vascular services and for cataracts. It is about providing those services in a smaller number of centres, but allowing increased output from those centres through consolidating the workforce better. We have been able to make a number of moves in relation to those. Later on this year, we are going to go out to consultation on establishing those day-case centres for all the conditions that will be treated. That is over 100,000 annually. Our view is that a Minister would probably have to make the final decision on where those centres will be located.

Q345 **Lady Hermon:** Thank you for that, but we have no immediate expectation that the Assembly is going to be functioning properly this



side of the summer. Mr Pengelly, you and I are regular correspondents. Much of our correspondence is about waiting times, the horrendous waiting times in Northern Ireland. We cannot allow people to suffer, to be left waiting and waiting and to get cancellation after cancellation. How are we tackling that? Regardless of when we see another Minister at Stormont, we cannot all be held hostage by the fact that Stormont is not functioning. How are we going to reduce these waiting times?

Richard Pengelly: We published an elective care strategy for how we will do that. It will be a twin-track approach. For the longer term, we need to reconfigure how we provide services. At the moment, the reason we have long waiting times is that there is a mismatch between demand and supply. Our capacity to deliver elective care does not meet the demands that are placed upon it. The transformation programme will recalibrate that and capacity will equal demand. That means waiting lists will no longer grow and in the future they will not rise. But that will not deal with the accumulated backlog, which is the bit that is of particular concern to you and other Members.

Lady Hermon: Yes, it is.

Richard Pengelly: The reality is that the only way we will deal with that is a long-term injection of finance. We need a long-term waiting list initiative. If I go back to 2014, waiting times in Northern Ireland were at an acceptable level. We were broadly hitting targets.

Lady Hermon: Yes, we were not bad then.

Richard Pengelly: In 2014, we were spending in the region of £80 million per annum on a waiting-list initiative. With the tightening of the financial position, since 2014 we have been unable to do that. Even if the money becomes available, we need to be aware that we will not be able to clear that backlog in the short term. It will take several years of additional activity within our system and some activity through the independent sector.

Lady Hermon: You said several years.

Richard Pengelly: It will be several years, I think. An approximate cost for managing the number of people on our waiting lists is £700 million. If I go back to 2014, we were getting in the region of £50 million to £80 million per annum. That is a rough indicator of how long it might take. Getting that amount of money will be a big challenge, but it is also about the capacity.

We used £30 million of the £100 million transformation money. We felt that stabilisation of the system is important while we seek to transform it, so we used £30 million of that for additional elective activity this year. The system has struggled to utilise that full £30 million. We will do it, but there is not much capacity within the system to do more than £30 million. In the short term, I would estimate that the independent sector would struggle to do much more than about £30 million per annum. So it



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will take many years to resolve that. The appearance of a Minister overnight will not fix that. It would certainly help us with it, but it is a money issue.

Q346 **Lady Hermon:** That is rather depressing.

Richard Pengelly: It is.

Lady Hermon: For the constituents I am writing out to with letters and apologies from trusts, things are not going to change any day soon.

Richard Pengelly: No, not in the short term. But, just to make this clear, we targeted the £30 million I referred to at both urgent cases and long-term waits. We are targeting on as intelligent a basis as we can to deal with the very tough cases. But it is just absolutely not acceptable that people are waiting as long as they are for treatment.

Q347 **Lady Hermon:** I am glad you say it is not acceptable, because it certainly is not, but I appreciate the explanation you have given. Finally, can I come to what I need to ask you? What preparations is your Department making for a no-deal Brexit? Presumably you have begun. Have you bought any fridges?

Richard Pengelly: No, I have not bought any fridges. The single biggest issue we face is medicines availability in the event of no deal. Plans are being laid on a UK basis by my counterparts in Whitehall at DHSC. The Secretary of State indicated that he had bought some fridges.

Q348 **Lady Hermon:** Exactly, that is the reference I was making. He has claimed that he has bought more fridges than anybody else. His new fridges are all in England, Wales or perhaps even Scotland, but we do not have any of his new fringes in Northern Ireland.

Richard Pengelly: A lot of the early activity has been on ensuring that sufficient supplies are available to meet UK demand for medicines. The issue we are focused on now—I was speaking to colleagues earlier this week—is ensuring the robustness of the supply chain, to provide us with assurance that, where those medicines sit in GB, they will be able to make their way through to Northern Ireland in a timely fashion.

That work is progressing and it is ongoing. Our colleagues in DHSC are in the lead on it, but I would want to put on record the extent of their engagement with us. They are sharing information with us; they are working with us. My colleagues will be dialling into a conference call this Friday, which will involve some of the pharmaceutical companies, to progress further the validation of those supply chains.

Q349 **Lady Hermon:** What period of time are you making preparations for these medicines to last for? Is it three months or six months?

Richard Pengelly: I cannot remember off the top of my head, but it is several months afterwards.

Q350 **Lady Hermon:** It is several months after 29 March, when we expect the



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UK to leave the EU.

Richard Pengelly: Yes.

Q351 **Lady Hermon:** You are confident that we will have in Northern Ireland sufficient availability of medicines.

Richard Pengelly: I am confident that, at this stage, we are doing all we can to ensure that is the case. Further detail needs to emerge. I need to be satisfied that the supply chain is there and is valid. There will be disruption to supply chains, particularly at ports. I have talked to my counterpart at the Department for Infrastructure yesterday, given their responsibility for ports in Northern Ireland. I want them to come along and be part of that discussion, because we need some validation from them about the free movement of those goods through ports.

Q352 **Lady Hermon:** Is that the first engagement you have had with them?

Richard Pengelly: No, there has been ongoing engagement, but it is now moving to a more granular level with colleagues in Whitehall and particularly with the pharmaceutical companies. I do not want that just to be a health issue, because it involves transportation. I want colleagues in transport to be part of that conversation.

Lady Hermon: Perhaps that is something you could give us an update on in a couple of weeks. You could write to the Chair and give us an update on further preparations. That would be very helpful. Thank you so much indeed. That is very interesting.

Q353 **Kate Hoey:** Thank you to both of you for coming. Can I ask you first, Mr Pengelly, whether you ever worry about the waste that goes on generally in hospitals everywhere? Do you ever talk to the people who work in hospitals, who will tell you quietly just how much gets wasted?

Richard Pengelly: I talk to them, and I go out and see it for myself. On the other side of Christmas, I visited 12 different locations throughout health and social care, including primary community care, secondary care, intensive care and children's homes. I was in Maghaberry prison, because we provide healthcare in prisons and police custody, to see things first hand. A year ago I spent a day in a theatre scrubbed up with a surgeon, just to get a sense of it.

Waste undoubtedly happens. Chair, as you will know from your own clinical time, quite often that waste happens in the heat of battle. It is difficult to say to a surgeon, "When a patient is lying in front of you, pause and think carefully about the cost of everything". I am focused on trying to create a culture of behaviour where we understand and recognise that everything has a cost. We must act responsibly. But I am very reluctant ever to try to put in place a bureaucratic process that interferes with patient care, because that is our prime reason for existence.



It certainly happens at an individual trust level for providers. They have all sorts of what they call QI, quality improvement, methodologies in place. They are asking individuals at a team level to think carefully about all their processes, all the steps in them, how they can streamline processes and how they can avoid waste. It is a big issue. There is no easy answer to it, but it is something we are acutely aware of.

Q354 Kate Hoey: Is there a need for public education as well? There are stories of people getting free prescriptions, with their cupboards full of things they have not actually used. Is that just apocryphal and nonsense?

Richard Pengelly: I do not think it is. My recently retired chief pharmaceutical officer told me a story a couple of months ago, which a colleague of his who is a community pharmacist mentioned to him. A client of his had sadly passed away, but he had to go out to the house to remove somewhere in the region of £6,000 to £10,000 of unopened medicines. Once a medicine is dispensed from a community pharmacy, it cannot be recycled back into the system even if unopened; it has to be destroyed.

One of the big issues in our transformation programme, particularly as regards IT, is e-pharmacy. Currently in Northern Ireland, for repeat prescriptions, you make contact with your GP, in many cases by telephone or letter. A lot of people with comorbidities are on a number of different medications. It is much easier to ring up and say, "Can I have my repeat medication?" rather than to say, "I only need that one and that one." Some of these drugs are unpronounceable. E-pharmacy will help that. It will help with the journey to primary care.

It also raises the spectre of prescription charges. My own view is that sometimes charging is not about money; it is about influencing behaviour. An issue you have alluded to is that, when we receive goods free, we do not always appreciate that there is a cost associated with them. I am not offering a position on prescription charges, but a debate needs to be had there, particularly in terms of cost recognition.

Q355 Kate Hoey: Most people over here would be surprised that it is completely free in Northern Ireland for everyone, no matter who you are. Could I take you on to something more terrible, really? I read all about the Muckamore Abbey situation over Christmas. What happened there is quite shocking. I know you personally went to meet the families, to apologise and so on. A couple of nurses were suspended very recently. Are we confident that there is a grip on what has been going on there and that it can be solved?

Richard Pengelly: I am confident that what is happening today has fundamentally changed from the behaviour that has happened. I cannot say with complete confidence that we know everything that happened, because I still have colleagues reviewing all the available CCTV evidence. I have looked at some of the CCTV evidence, and I was shocked and appalled by what I saw in some cases.



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Q356 **Kate Hoey:** There was a review, was there not? It was *A Way to Go*.

Richard Pengelly: There was a review to try to determine what happened, but the full review of the CCTV coverage and the necessary PSNI investigation—

Q357 **Kate Hoey:** Should there be a public inquiry? Would that help? I know they are expensive and take a long time, but it would help if the families felt that something had been found out.

Richard Pengelly: Even under the legislation that has been passed, I would not be able to initiate a public inquiry. That could only be done either by the Assembly or by the Secretary of State. The point I made to the families was that, with that said, if a public inquiry was initiated today, I suspect the first thing that would happen is that it would adjourn until the police investigation concluded. The police investigation is ongoing. I met with senior officers last Friday, primarily to offer them any and all support we can give them in their work, to assure them they can speak to any colleagues or obtain any information they need, either on the specifics of the investigation or the necessary background and context.

I do not say this in any way to excuse what happened, but there were a very challenging set of behaviours happening in Muckamore due to the patient cohort. With that said, they absolutely must be treated with respect and courtesy, and have dignity at all times. Anything less than that is unacceptable. A public inquiry would not be able to move at this stage. This is the point I made to the families: I am not saying there should not be a public inquiry. I am saying the time to answer that question will be when the police investigation has concluded. Hopefully there will be a Minister in place to do that.

Q358 **Kate Hoey:** Are the systems in place to ensure that what went on for a very long time could not happen anywhere else in an institution that you are ultimately responsible for?

Richard Pengelly: It would be difficult to give an absolute categorical assurance that that is the case. I sincerely hope it is the case. I have made the point to the chief executives of all trusts. I wrote to the trust chief executives last week. I am bringing them all in for—I do not like to use the word—a summit specifically on this, to talk about the cultural issues. I would say that Muckamore is different to any other institutions we have, given the patient cohort. I am assured that the culture and attitude have changed in Muckamore, so what is happening today is different from the period under review. The main reason I am meeting with trust chief executives is to develop an action plan to make good on my commitment that a year from now nobody will call Muckamore their home, because we have people who have been there for far too long. We need to get them into a more appropriate and more beneficial environment.

Q359 **Kate Hoey:** Finally, how often do you meet with the Secretary of State?



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Richard Pengelly: I have had one meeting with the current Secretary of State.

Q360 **Kate Hoey:** You have had one meeting with the Secretary of State since she was appointed. What about the junior Minister, although it changed?

Richard Pengelly: I think I had a couple of meetings and a few telephone calls with the previous junior Minister.

Q361 **Kate Hoey:** Would you feel happy about literally picking up the phone and asking to speak to the Secretary of State?

Richard Pengelly: I have a good relationship with my colleagues in the Northern Ireland Office. I am comfortable, although I have not tested this, so I cannot offer you assurances. If I felt I needed access or there was an issue of such significance that I needed that conversation, I am confident it would happen. An issue has not arisen. The current and ongoing management of health and social care is still my responsibility, rather than the Secretary of State's.

Q362 **Ian Paisley:** Richard and Jackie, thank you for your evidence so far. I welcome what you have said with regards to Orkambi and cystic fibrosis. I wish you well in that negotiation. I know it has been very difficult, but I understand progress has been made in England and it would be welcome to see that flow into cystic patients in Northern Ireland, in particular young people. You mentioned that the confidence and supply money had made a real difference at a significant time. That is good for this current financial year. I am delighted that your Department has been able to break even under your careful management. What about next year? Will confidence and supply money be available to you then? How will you make adjustments?

Richard Pengelly: We are proceeding on the basis that the confidence and supply money will be available. That is particularly relevant in the context of the transformation fund. We had £100 million in 2018-19; we are planning for £100 million to be available next year. We are planning the continued rollout of transformation programmes. Again, a chunk of that £100 million we will use for another investment in waiting times, to try to alleviate the most critical and the longest waits.

Q363 **Ian Paisley:** Is it right to say that without that money—I am not saying you would not be able to deliver the transformation programme—it would be much more challenging to deliver it?

Richard Pengelly: I would tend towards saying we would not be able to. There would be small elements of it. The delivery of the transformation programme is defined as delivery of the majority of the programme. If you only deliver something round the edges of it, you are not delivering all of it. That £100 million has been absolutely central to us taking it forward. If we go back to the *Delivering Together* document, which the Executive agreed in October 2016, the Executive paper made explicitly



clear that transformation money would be required to deliver that journey.

One of the reasons that successful implementation of the previous attempt at transformation, *Transforming Your Care*, was difficult was because transformation funding was not available in parallel with its rollout.

- Q364 **Ian Paisley:** Thank you for that. It is progress, which unfortunately in the current political debate is probably largely lost, but what you have said is welcome there. Reading between the lines, Richard, is it the case that you as Permanent Secretary and your officials have to take a lot of legal advice before you make these decisions, because of the fear of litigation or pressures on you because there is not a Minister in place? Do you have to resort more regularly to legal advice and legal direction?

Richard Pengelly: We do, but oftentimes the legal advice we get on a specific issue sets out a series of principles that we must consider, so when another issue comes along we do not need to revisit the specific legal advice. You will have to indulge me in paying tribute to my colleagues in the Departmental Solicitor's Office for both the quality and the timeliness of advice. They are under intense pressure because of the absence of Ministers but also because of Brexit issues. They have been providing us with a fantastic service.

We seek that advice. In a lot of the decisions I am dealing with, the big issue is the question: am I likely to be challenged for this? For some of the decisions I have taken, for example in making medicinal cannabis available to a child, the risk of legal challenge is pretty low, so I do not need to seek the same extent of legal advice as colleagues in other Departments who are dealing with things where the chances of challenge are very high.

- Q365 **Ian Paisley:** We are not at the point where it is government by lawyers, but they are playing a very significant role in allowing you to take decisions that you are comfortable with and you will not be challenged on.

Richard Pengelly: Yes, absolutely.

- Q366 **Ian Paisley:** You have mentioned pharmacists on a couple of occasions. I am delighted with the news. Probably every Member from Northern Ireland has been in communication with you about that because of the pressures on our local community pharmacies. You paid really glowing tribute to pharmacies. I think you said they are just too valuable and too important for your Department to forget in any programme going forward. What sort of role do you see community pharmacy playing in the transformation of the health and social care system going forward? How are they strategically going to be engaged in that?

Richard Pengelly: I will maybe broaden it away from community pharmacists to pharmacists in general. One of the issues we are rolling



out is practice-based pharmacists, so embedding pharmacists within GP practices. That is strategically important because it brings a source of expertise, in terms of the prescription of drugs, to individuals. Operationally, it is important because it relieves the burden on GPs. There are things GPs are currently doing that pharmacists can do and, frankly, can do better, so it frees up GP time.

The slight negative with that is that many of the embedded practice-based pharmacists have been recruited from community pharmacy and it has caused some issues there. I have recently asked the Health and Social Care Board to pause on the next phase of recruitment, so that we do not compound the issues in community pharmacy.

The linkages between primary care and community pharmacy can grow. We need to build on the work that has gone on in the past, in signposting individuals to community pharmacists, who are a tremendous source of advice and guidance, particularly about minor ailments. We have the minor ailments scheme. In principle, that was well aimed. The application of it was maybe not all it could have been, and we need to rethink that.

Last year, I convened a meeting of the BMA, the Royal College of General Practitioners and community pharmacists, to open up the conversation about how we can better gel primary care and community pharmacy. Are there opportunities to reposition some activity and, frankly, some funding? One of the issues the GPs raise repeatedly to me is that it is not a financial issue; it is a workload pressure issue. Pharmacists can take some of the strain. There is also an opportunity for self-management for some low-level conditions. There is a big role for them to play. We want to talk to community pharmacy about the availability of transformation funding and the opportunities there.

Ian Paisley: Hopefully your discussions will improve the cash flow internally for a lot of these pharmacists, because you know the pressures.

Richard Pengelly: Yes, absolutely.

Q367 **Ian Paisley:** They are dipping into their savings. Some pharmacists I know are not even being paid at the moment because they are trying to keep their practice afloat. It would be good to see that come to a solution. My final question is about the human milk bank. As you know, it closed for about nine months the year before last and part of last year, which created real pressures, especially on premature births and children with significant needs who depend on human milk. I am delighted that it is open again. What steps have been put in place to ensure that, if there is another bacteria, another problem, or indeed a chronic shortage of supply, we have linkages here with the mainland, or maybe even with the Republic of Ireland, getting the milk to Northern Ireland?

Richard Pengelly: I would need to come back to you on the granularity of that. I have talked to the chief medical officer and I know steps have



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been taken, but in terms of the detail of that, if it is okay, I will come back to you in writing on that point.

- Q368 **Ian Paisley:** Okay. While I have you, I want to commend the work the milk bank does. Importantly, when it had very significantly depleted stocks, I know that my own hospital, the Antrim Area Hospital, and others, went above and beyond the call of duty in getting milk to prematurely born children in Northern Ireland. That was very significant and indeed, in specific instances, lifesaving. I welcome the ingenious way that they were able to get resources from the British mainland to Northern Ireland. It is an opportunity to pay public tribute to your staff.

Richard Pengelly: I will certainly make sure they are aware of that.

- Q369 **Maria Caulfield:** I just wanted to go back to a few of the issues that have been raised by my colleagues. It sounds like you are doing fantastic work. All praise and tribute to you and your team for having to keep things going in the absence of an Assembly. But it does not rule out the fact that Northern Ireland, compared to the rest of the United Kingdom, has some of the worst health outcomes. We have raised some of those today, whether it is cancer, suicide, diabetes, waiting times. In your opinion, does not having an Assembly contribute to that?

Richard Pengelly: First, can I emphasise that I think we have poorer performance than counterparts across the UK on a range of measures, waiting times in particular? We need to be careful in terms of outcomes, not least because I do not want to scare members of the community. If I look at cancer outcomes, five-year survival rates for cancer in Northern Ireland compare very favourably to the UK. We compare very poorly in those activity metrics and how we deal with the 14-day red flag, the 31 and 62-day targets, so there are issues there.

The key point is whether the absence of the Assembly contributes to that. The absence of the Assembly is important in terms of the transformation agenda, how we take it forward and the pace we take it forward. I have never aspired to be a Minister. I would particularly want to avoid being the next Health Minister, because my worry is that there will be a sense in the community that the first day in business, with one sweep of their pen, they will solve all our problems. The problems remain. We have a flawed structure and configuration for health and social care and we are short of finance today, particularly, given the points on the accumulated backlog. The availability of an Assembly provides a context in which we can start to address those, but the Assembly coming back tomorrow will not, of itself, bring more money into the system.

- Q370 **Maria Caulfield:** Is there not a problem, not having a Minister to make difficult decisions about reconfiguring services or reallocating funding, or even having the scrutiny of the service to push those who are Ministers into making decisions that will make a difference for patients in Northern Ireland?



Richard Pengelly: It absolutely does, particularly the scrutiny point. The point I made earlier was that we have been lucky, because we have had the transformation strategy that was passed shortly before the institutions collapsed in Northern Ireland. That was a 10-year transformation strategy. The reality is that the first couple of years of a 10-year strategy are going to be about low-level hard work, analysis, developing options, before you come back to Ministers for the next set of strategic and difficult decisions. We have benefited from having that year or two of doing that.

If the absence of Ministers continues, we will absolutely start bumping into these very difficult decisions. We touched earlier on the consultation we did on the reconfiguration of stroke services. There are potentially some very difficult decisions in there. We need to bear in mind that the legislation, I think, only covers us to August, in terms of the decision-making power of officials.

Jackie Johnston: We have really good momentum going across health and social care in Northern Ireland. It is absolutely amazing, the engagement between colleagues right across all the trusts, in driving these transformation projects. As Richard says, we get to the stage where there are difficult decisions to be taken, probably in the year ahead, because that groundwork has been done. To continue that momentum is vitally important if we are going to deliver the transformation. That is where I see the missing piece.

Q371 **Maria Caulfield:** Lady Hermon indicated that there is a possibility there may not be an Assembly this side of the summer. Given you are coming to a point where you have made as many decisions as you are able to make in your role, and say the Assembly does not come back until much later this year, is there not a case now for the Secretary of State having to make some legislative changes or legislative decisions that will enable you to facilitate the work you have been doing?

Richard Pengelly: Inevitably, there will come a point when there is a list of decisions that we have concluded we simply cannot take, even with the support of the new legislation. At the moment, because of the previous coverage, I do not feel I am at that point yet. I do not feel I have a long list of decisions that are of such significance that I need to say, "I cannot proceed any more". It is my responsibility to keep going.

Q372 **Maria Caulfield:** How far away are you from that point?

Richard Pengelly: It is hard. I would have thought probably at least a year.

Jackie Johnston: Yes, although there is always a clear public interest in health, in terms of, when you make that assessment, whether you take a decision or not. That has its limits as well, I suppose.

Q373 **Maria Caulfield:** I found it quite shocking when you replied to Kate Hoey that the Secretary of State has only met with you once. Would it not be



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more helpful for her to meet with you on a regular basis, particularly around Brexit and the possibility of a no-deal Brexit, so there is someone in the Cabinet, in Westminster, fighting the corner for health services in Northern Ireland? Would you find it helpful to meet with her more regularly?

Richard Pengelly: I need to be absolutely fair to the Secretary of State. The fact that we have met once is distinct from the ongoing dialogue I have. Colleagues in the Northern Ireland Office, who support the Secretary of State, would be in more frequent contact with me and would want to understand issues. They have made it explicitly clear to me that, if there is an issue of such complexity and difficulty that I need to engage with them, with a view to putting it towards the Secretary of State, that mechanism exists. At this stage I have not been faced with an issue where I need to exercise those options.

Q374 **Maria Caulfield:** I know time is brief, but just to focus on one specific area of suicide, suicide rates in Northern Ireland are the highest across the United Kingdom. We have heard in other evidence sessions from those from a clinical background that the lack of an up-to-date suicide strategy is holding back services, in terms of prevention and helping people who are at a crisis point. My understanding is that it is not coming into force because there is not an Assembly. Is that correct?

Richard Pengelly: No. This is the issue now with Protect Life 2, the new suicide strategy. With my enhanced powers under the new legislation, I can sign off on it. I just want to be satisfied that the costs associated with signing off on it are affordable within the budget. I have not yet been allocated a budget for the next financial year. When I get that budget, my sincere hope and expectation is that I will be able to move to formally implement that strategy. I want to do it as quickly as I can. Perhaps unlike a Minister, I also carry the responsibilities of accounting officer and value for money. I am acutely aware that every pound I spend on something means a pound less to spend on something else. I need to see that in the financial context.

Q375 **Maria Caulfield:** It is the actual budget allocation for next year that is stopping you.

Richard Pengelly: Yes, so it is not an authority point.

Q376 **Maria Caulfield:** Westminster legislated for the budget for this financial year. Many of us made the point to the Secretary of State that it would be helpful to legislate for the coming financial year. Is that something that should be done as a matter of urgency?

Richard Pengelly: In my view, yes, not just for this year. The sooner I get a budget for 2019-20, the sooner I can start to plan for that. When I do get a budget, the one thing I can say with certainty is that I will view it as insufficient in terms of all the financial challenges I face. The options open to me to make financial change in 2019-20 are completely different from the options open to me to deal with the financial year two or three



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years into the future. For short-term planning, the only things I can stop are the things I am physically able to stop, as opposed to maybe the things I should stop. I would not only welcome a budget for 2019-20; I would love a budget for the next two or three years to undertake that long-term planning. I think I could make bigger, more significant change in that context.

Maria Caulfield: That is very helpful.

Q377 **Chair:** Operating with lots of financial headroom obviously helps in bringing forward services, and they are uncontroversial and are unlikely to be subject to judicial review. Far more difficult, in the context of longer-term planning, is making those difficult, crunchy decisions on, for example, the healthcare footprint across Northern Ireland. That is where you are going to run into problems without Ministers, is it not?

Richard Pengelly: It is. Part of the obligation on me and my colleagues—if I am honest, I do not think we have done this particularly well in the past as a service—is to move the debate. Liam Donaldson, the previous chief medical officer in England, was over in Northern Ireland a few years ago. He used a phrase: “Sometimes I think in Northern Ireland instead of a National Health Service you have a national building service”. We talk too much about the bricks and mortar of hospitals and buildings. We need to change the debate to the services.

We need to talk about stroke services. How do we meet the needs of the population in Northern Ireland, in terms of the provision of stroke services? The model I take is primary PCI, where we have moved to a two-centre model. Quite often, when people have a STEMI, they are driven past all their local facilities to either Belfast or Altnagelvin. We outperform anywhere else in the UK in the provision of primary PCI with the two-centre model. We do not seek to provide it everywhere, but we provide a fantastic service. I met recently with an individual and his wife who had utilised that. It saved their life. If we get the debate on services, the conversation becomes less difficult. Jackie would make the point, in terms of stroke, on the availability of HEMS, the helicopter service, and greater utilisation of it. Distances are contracting.

Jackie Johnston: Yes, timeliness of access across all services is where we want to focus improvement. Again, the old adage is to have the right care in the right place at the right time. That is the overall motivation for this.

Q378 **John Grogan:** I will be very brief. I must say I found the evidence very informative and impressive. I just wanted to come back to one point that Lady Harmon made on the pay. I think it may relate to multiyear funding as well. I understand across the United Kingdom a very comprehensive pay deal was done between the unions and the Government. It is not an easy thing to do on either side, so I think both are to be commended for doing it. Is it that you have managed to work out this one year so far? You said there were some outstanding issues with the unions and so on.



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Is it because there is not multiyear funding in place that you have not been able to implement it in the same way as in the rest of the United Kingdom? I was just trying to clarify that I understood it.

Richard Pengelly: Sorry, it was remiss of me not to say this, so thank you for the opportunity to clarify it. A three-year deal has been put in place elsewhere in these islands. In Northern Ireland, it is a one-year deal. There are two prongs to it. I do not have a financial settlement for years two and three of that. Also, despite the legislation, our guiding principle is still that, if decisions can be left for Ministers, they should be left for Ministers, so I think it is appropriate that I take a one-year deal. Our staff do such a fantastic job they need a pay award. They need to be rewarded for that. If there is a possibility of the Minister coming back to reflect in years two and three, it is better that I leave that and leave the flexibility for Ministers.

Q379 **Lady Hermon:** This is something that has puzzled and concerned me since the evidence that was given to the RHI inquiry, where it was suggested in evidence, I think more than suggested in evidence, that some Ministers, and I do mean some Ministers, in the previous Assembly had apparently given instructions to civil servants not to take minutes of meetings. Could we just have clarification around this point that, in your case, you have minutes taken of all meetings that you have with politicians?

Richard Pengelly: Yes, where it is appropriate to have minutes. If you mean all meetings with all politicians, for example, on a regular basis an elected representative would write to me to say, "Here is a specific issue. Can I come in to talk to you about it?" They would come in. Certainly there would be a record of the meeting having happened and what the issue was about, but we would not transcribe a note of what was discussed in that meeting. It would be to talk about an issue and maybe respond to some questions the elected representative had.

Q380 **Lady Hermon:** Could we have an assurance? We understand from the evidence that you have only met the Secretary of State once, and I can see the reason for that, because health is a devolved matter and you are in charge, in the absence of a Minister. Let us say there was a delegation from Sinn Féin with MLAs. They are perfectly entitled to meet with you. I am not suggesting otherwise. Surely to goodness, there would be minutes kept of meetings with delegations and politicians from whatever party on a regular basis. Are minutes not kept of those meetings?

Richard Pengelly: No, not necessarily.

Lady Hermon: Really?

Richard Pengelly: I spend the greater proportion of my working life in meetings of one type or another. Where it is appropriate and necessary, a record is kept, particularly to capture action points or where matters are agreed. In the current context, in the vast majority of meetings I have—and you give an example of a delegation from one party coming



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in—they are coming in to seek information from me on a particular issue. It is not that we are making decisions about how money is spent, or about actions within the Department. It is completely different from a meeting with a Minister, where there is the exercise of authority; there is decision-making. We need to recognise that keeping minutes of every single meeting would have a huge administrative cost.

Q381 Lady Hermon: There is a huge administrative cost for someone to just sit in the room and take a note of who was there. Most charities, most organisations, keep minutes of meetings.

Richard Pengelly: Think of every meeting that happens throughout health and social care on a daily basis.

Q382 Lady Hermon: I am actually asking about meetings with you, if you do not mind me saying so. As the Permanent Secretary, you are in charge of health at the present time. You are not elected. We need some level of accountability. I was actually asking the question for you to say to me, "Do not worry. There is no need to worry because in fact we do keep minutes of all the meetings". That was my expectation, so I am rather confounded and surprised by the fact that you have said the opposite to what I was expecting.

Richard Pengelly: Apologies if I have caused some concern. I am focusing on you asking about minutes of meetings. The important thing is that we have a record of meetings. It is important that there is a record of a meeting having happened and who has attended. A record of meetings will exist. What I am saying is that there is not necessarily a detailed recording of every single item that was discussed and the nature of the conversation. That is because the vast majority of these meetings are information-sharing. That is to say they are not a forum for decision-taking. It is much more important to have a more granular record where decisions are taken and where authority is being exercised, but that is not the context for those meetings at the moment. There is a record of the meeting.

Q383 Lady Hermon: You have a policy that, when a decision is being taken, minutes will be kept of that meeting and how that decision was reached. There is a distinction between information-sharing and decision-making.

Richard Pengelly: In the current environment, decisions are never taken in the context of meetings between me and elected representatives. Where I take a decision, I do it on the back of a detailed submission from my colleagues, which articulates the rationale, the issue, where necessary the legal advice as to whether I can make a decision, and a recommendation. On that, I will record my decision. Where I am taking decisions, there is a very substantive record of the rationale for that decision and the basis on which it is taken.

Q384 Lady Hermon: Those decisions are taken with colleagues. You made it quite clear when you just said to us that in fact decisions are never taken with politicians.



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Richard Pengelly: At the moment, elected representatives in Northern Ireland have no authority for decision-making, so they are not part of the decision-making process, absolutely not.

Q385 **Lady Hermon:** That is very helpful and very clear. I appreciate that clarification of what was very disturbing evidence, as was much of the evidence given at the RHI inquiry. It was particularly disturbing, but that was an aspect I wanted clarification on, and you have provided that, in the end.

Richard Pengelly: Sorry it took me so long.

Lady Hermon: No, we have just worked through it. I am happy.

Q386 **Chair:** Finally, what do you think the effect of a lack of Ministers has been? You painted a picture of things actually proceeding reasonably well with no huge backlog of things waiting on the incoming Ministers' desks for decision. I am puzzling here, because I am thinking of Ministers as terribly useful people, and yet you seem to be managing things perfectly well in the absence of a Minister.

Richard Pengelly: I too take the view that Ministers are terribly useful things. I would love to have one. As I said earlier, Chair, the fact that we had the Executive-agreed transformation strategy agreed a short time before the current hiatus started has been good fortune on our part and been incredibly helpful.

The one area I would point to where we suffer at this stage is the extent of the public debate about the challenges. The legislation has given me the ability to take some decisions, but I cannot, as a civil servant, enter the public debate. I can explain policies, but it is not my role to justify or advocate policies in the public debate. From my perspective, we really need a refreshed, detailed public debate in Northern Ireland about what we expect from health and social care and how we fund that. That requires democratically elected representatives to lead and participate in that debate.

Q387 **Chair:** I do not expect you to second guess your colleagues in other Departments, but if we had Perm Secs from other Departments, who were not in the fortunate position you have described, they may take a different view, would you say?

Richard Pengelly: They could well do. For example, I look at my counterpart in education. As much as health service needs to reform, people accept our education service in Northern Ireland needs reform. They do not have a transformation strategy, so that is a much more difficult issue for my colleague over there.

Q388 **Chair:** Can I draw you a little further on those crunchy issues I mentioned earlier, probably pertaining especially to education, but also to healthcare? That is to say that there would be a tendency, because you are civil servants and therefore instinctively careful and cautious, and



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particularly given the judicial review issues that have arisen recently, for you perhaps to avoid taking decisions on, for example, the buildings you referred to. Of course, they would naturally conflict with opinion in parts of the community at least, and therefore be likely to attract the interest of lawyers.

Richard Pengelly: It is easy for me to say this. I would hope I do not ever fall into that trap. For me, I carry the responsibility of trying to improve health and social care and to meet the needs of the population. I carry that responsibility very heavily. It is of fundamental importance to me. I sincerely hope that I have not and will not ever shirk a difficult decision that may, ultimately, involve me spending some time in a judicial review. If it is the right decision and I have the power to take it, I hope I have addressed it. Maybe Jackie is better placed than me to offer a view. My attitude is that I should never shirk those because they may be controversial. If I have the authority to take it and it is the right thing to do, I have a responsibility to do it.

Q389 **Chair:** That is within the guidance that you have been issued, of course.

Richard Pengelly: Yes, within the guidance. It must be lawful.

Q390 **Chair:** We have heard about things like prescription charges and community pharmacy, for example. All these issues, potentially, might be in scope, were there Ministers available, in order to deal with other things like the waiting list initiative, for example, which is something that is urgently needed. Unless one assumes that the financial headroom is going to be increased dramatically to deal with that, one clearly has to look at the way one's services are configured. If you start doing that, it starts bringing you up against controversy. That is, properly, the bailiwick of Ministers, is it not, rather than civil servants?

Richard Pengelly: I think so. My point is that I should not avoid controversy because I personally find it uncomfortable. If I have a decision to take, and it is lawful for me to take that decision, I should take that responsibility and make the decision. There are some things that would be inappropriate for me, as an unelected civil servant, to take on. I need to pay close attention to that.

Chair: Gentlemen, you have been extremely helpful. Thank you so much. I think I speak for the Committee in saying this has been one of our most productive sessions in recent history. We are terribly grateful to you for being here today.