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COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

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(Hansard)

Departmental Briefing on the 2011-12 Resource Budget

29 June 2011

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Mr Sam Gardiner
Mrs Pam Lewis
Mr John McCallister
Mr Kieran McCarthy

Witnesses:
Ms Catherine Daly)
Dr Andrew McCormick) Department for Health, Social Services and Public Safety
Dr Norman Morrow)
Mr Peter Toogood)

The Chairperson:

Peter, Norman, Andrew and Catherine, you are all very welcome. It is good to have you back at the Committee. I understand that you will make a 10-minute presentation, followed by questions from members. I will say at the outset, although I have a feeling that I may have to repeat myself, that I would like people to keep their contributions succinct and relevant to the matter being discussed. If people work with us, we will try to keep questions and answers from becoming too

long-winded and keep a close eye on the time. Thanks a million. Fire away, Andrew.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): Thank you very much, and thanks for having us back to take the budget briefing further. There are still limits on what we can talk about, because some things are still with the Minister for his consideration. That means that the paper that we were able to provide indicates many of the areas under consideration, but I acknowledge that there is further detail to come. The honest answer is that such detail concerns issues that are still being considered by the Minister. We will do our best to expand, and I hope that the paper was of some help in moving the issues forward. We will do our best to expand on it in answering questions, but please bear with us if there are occasions on which we must say that a matter remains with the Minister.

For the current budget for 2011-12, we have the general, unresolved problem of a gap of £177 million, which was identified at the previous Committee meeting as our starting point for our figures. We have identified steps to reduce that. For today's purposes, I ask members to bear in mind the figure of about £72 million as the amount that we have not yet resolved. The Minister used that figure in his discussions last week and it has appeared in the press, so it is a good yardstick.

We are still working closely with the Department of Finance and Personnel (DFP) colleagues. Major work is under way in the performance and efficiency delivery unit (PEDU) review to try to identify all possible measures to close that gap. We are also in further dialogue with the Minister and his team, including his Assembly special adviser. A lot of work is going on to identify ideas, and that links back to the discussion that we had last time around. Therefore, we are still in that phase of working with the Minister, his team and DFP to identify measures. There will be further points that can be made; further amounts that can be dealt with; and we will get the detail to you as soon as there is clarity. However, we will give as much information as we can today and promise that there is more to come. We will keep you informed over the summer recess, in the way that you described earlier, Chair.

We are also still in dialogue with the trusts to seek firm reassurances that their plans are sufficiently robust and effective to deliver the completion of the required savings. We are currently in the last spending period. Last time round, we talked about the figure of approximately £80 million that the trusts needed to achieve to complete the efficiency savings in

the period up to the 2010-11 financial year and to make those savings recurrent.

That is challenging, because there are a number of issues. Chair, I take the point that you made in your introduction that it is important to look at it as a whole-system issue and ensure that we make the changes in the right order. There are significant pressures in the community sector, in domiciliary care. It is important that we receive an assurance that that is working effectively before moving into other areas of reduction.

Other areas that we continue to look at include the length of stay and management. That involves working with primary care to try to find in which it can absorb more of the work and ensure that that work is filtered properly so that acute hospital time is used only when appropriate. If there are smarter and more effective ways to make that happen, that is exactly what should be done. On that basis, we are looking at ideas, old and new. An extremely important element of the thinking of primary care partnerships (PCPs) is how to secure better demand management and improve the handling of all those issues.

All trusts, as part of what they do in that package of savings, are maintaining tight control of all non-pay expenditure and looking at smarter procurement. The Health and Social Care Board (HSCB) intends to take any possible further action to bear down on existing costs, such as considering more regional single-supply contracts and other items procured for the acute sector. Major areas of expenditure include drugs and other consumables; smaller ones include the travel bill. All are under continual scrutiny. Again, we will give you details of decisions as they are made and as the Minister is ready to proceed with them. Quite a few issues, even within the package of savings that the trusts need to make, are with the Minister for his consideration, and that is important.

Last time, there was considerable discussion on pharmacy issues. Norman is here, but he must attend another meeting today. Therefore, if it is possible to deal with pharmacy issues early in the discussion, that would be helpful, and we will do our best to facilitate that. I want to pick up on several points from our previous meeting. We can explore those issues further in discussion if you wish. I hope that the paper was helpful in drawing out the achievements to date of the improvement programme that began in 2005. That programme has been a major drive in securing significant savings. It has been very successful and achieved significant advances.

To be clear on what we are saying, I will go back to the beginning of the story. A firm policy and a great deal of correspondence instruct the system to use generic drugs. That is on record and has gone to all sectors. We look for good prescribing practice in all sectors in primary and secondary care and for that to be delivered in the best way possible. It is not absolutely enforceable because our relationship with GPs is contractual. GPs are not employees; they are independent contractors. Therefore, we give guidance and a clear statement of policy. As our briefing paper draws out, an element of the General Medical Services (GMS) contract relates to prescribing performance. There is also guidance on good prescribing practice as part of good professional practice, but there are some limits.

Paragraph 26 of the paper, in the section that deals with pharmacy issues, states that further action could be taken to provide "further exhortation" and "promotion of good practice" along the lines of the approach taken in the western area, which we discussed previously. Again, just to be clear, the approach there was mainly the encouragement and promotion of the application of existing policy. There was no magic bullet in what was achieved. We are pleased by the extremely positive achievement of the western local commissioning group (LCG) in the Castlederg area. However, the fact is that its generic rates were already below the Northern Ireland average. It is not possible to extrapolate a figure from that and multiply it to work out what can be done. Therefore, I am afraid that the figure of £61 million does not exist as a saving; it is not available. It was a figure extrapolated from that data. It does not work that way, I am afraid.

Another possible step would be the publication of data at GP practice level to highlight those who are most and least compliant. That is a way of publicising and drawing attention to the issue. As the Committee put to us strongly at our previous meeting, there is no good reason for not proceeding with very good practice in generic prescribing.

Any further developments on the contract depend on what happens at a UK level. At present, we have a commitment to a four-country contract. We need to determine whether there are ways to influence the UK-level negotiations to promote more demanding and stronger sanctions. That is a matter for consideration. We have to judge carefully the right thing to do. Our paper also includes a short section on generic substitution, but that is not under active consideration at this time.

The other important point to make is that there are genuine reasons why there will never be 100% prescribing of generics, the most obvious being that so many drugs are still not off patent and can be prescribed only as branded drugs. It is important to highlight the ratios involved. Generics account for approximately £100 million of the £400 million of drugs prescribed. That is the gearing: many low-cost generic products and a lot of high-volume prescribing. Over 60% of the items prescribed are generic and dispensed generically, but, for good reasons, that proportion is not reflected in money terms.

The newer drugs are high cost, but many important drugs that are being prescribed are available only as branded medicines. The position is always changing. As new products reach the end of their patent, the generic versions become available. All those issues depend on the way in which the market works. That is one very strong reason why we will never have 100% generic prescribing. There are also some genuine situations — they are set out briefly in the paper — in which it is not clinically the right thing to do to prescribe generics. Those situations are quite limited, but they are important. In those cases, the therapeutic value of the product is such that it is justified and right to prescribe a branded version — that is important. Also, some branded products cost less than their generic equivalents. Although they may be coded in our statistics as branded dispensing, they are, in fact, cheaper, so we need to be careful with the numbers.

We are doing everything that we possibly can to secure savings in that area. The target of £30 million in further savings set for the current year will be demanding. We cannot specify exactly the maximum possible percentage of prescriptions that could be filled generically, but we think that we are quite close to the limit. England is extremely close to the limits. We aspire to do the best that we can, but we want to set out the factual reasons why significant limits exist.

It may be best to leave it there, Chairperson, and proceed to questions. If there are other issues to pick up from yesterday's statement, we are more than happy to do so. Given that this is the last meeting before recess, it might be helpful to the Committee.

The Chairperson:

OK. Do you want to come in at this point, Norman?

Dr Norman Morrow (Department of Health, Social Services and Public Safety):

I am happy to answer questions, Chairperson.

The Chairperson:

A few members have indicated that they wish to ask questions. Andrew, you said that there were measures that could be taken. Again, that begs the question: why have they not been taken? We understand the issue of patents and generic drugs not yet being available. However, surely it makes sense to carry out that work. Rather than thinking about it, talking about it and considering matters, surely it should just be done.

Dr McCormick:

For the past number of years, the approach has been to specify a clear policy of generic prescribing and dispensing. It is, then, about seeking to promote the application of that policy. There is nothing missing from the policy; what is missing is its full delivery by prescribers. Part of our approach involves working with pharmacy advisers, the board and others to promote good practice.

The Chairperson:

Are there sanctions for clinicians who do not prescribe according to the policy?

Dr N Morrow:

The GP contract does not appear to include sanctions. There is a statement about "excessive prescribing", but, in some ways, it is relatively imprecise. During my time in this office, no one, as far as I am aware, has taken any issue under that term. Over many years, the approach has been one of persuasion and asking people to conform to the policy. The board has said that it would like to be as robust as possible, mainly through the use of their prescribing advisers. The advisers, in discussions with GPs on their prescribing performance, should constantly draw attention to the standards and targets. Last week, I went along with the advisers to get a sense of how GPs were being called to account for their practice. Laid out before those GPs was how their prescribing behaviour compared with other practices and Northern Ireland as a whole.

Much focus has, rightly, been placed on the use of generic medicines. We should get the best value. However, that is not the only strand of our work on good prescribing practice. Other factors in choosing the most appropriate medication are its cost-effectiveness in the wider world

and whether it is available only as a branded product or whether it is also available as a generic. The issue of generics in prescribing efficiencies is only one part of our strategy. Another element is good prescribing behaviour that complies with national or local guidelines. There are also issues with the procurement of medicines, particularly in the secondary care sector. In other words, all measures that contribute to the quality and safety of prescribing must be considered. The argument is won and lost on quality and safety, not necessarily on money alone.

The Chairperson:

We do not want to look as though we are picking on GPs. My GP practice has been very responsible. Having been there a lifetime, I know that people are very often prescribed generic drugs ahead of the branded products. However, that does not happen everywhere. Some clinicians and other medical staff in hospitals do not think about their capacity to save money and prescribe branded products when generics are available.

Andrew, you talked about "smarter procurement". That includes issues such as use-by dates and the dates on which drugs are bought. If very expensive drugs are bought but not used within their use-by window, they can cost the Health Service a huge amount. I welcome the fact that you talk about smarter procurement, but, after I do not know how many years, persuasion is still being used. How long do you plan on using persuasion? Sometimes, we need to step it up and go from persuasion to coercion.

Dr N Morrow:

I take your point entirely. I want to make a comment about the persuasion argument. In 2005, as Andrew will remember, I drew the short straw and tried to lead the work to save £55 million. However, at that time, the change in generic prescribing from year to year was one percentage point. In 2005, the rate of generic prescribing was 43%, and it is over 62% today. That represents a three-to-four percentage point shift each year, so there has been a substantive change in the way that we moved the generic prescribing targets over that period. We still have some little way to go, but that improvement was achieved through a "persuasive" approach.

The Chairperson:

I am not sure that I would agree with the phrase "short straw". I am sure that you were well rewarded.

Mr Wells:

I congratulate you, Dr Morrow. You are the first witness to know the difference between percentages and percentage points. Up to now, people have talked about a 3% increase when it was an increase of three percentage points. The importance of that is vital in assessing such issues. I am pleased to hear that, because the vast majority of folk with whom we deal do not understand the difference.

That said, my view is that every GP who, under your regime, deliberately decides to go for a branded product rather than a generic one might as well stand by the side of the Lagan and pour £20 notes into the river. Realistically, that is what is happening. The relationship between the Department and the GPs is quite revealing. Cleary, it is a question of your saying "Please, Mr GP, could you do this, but if you do not, we cannot touch you."

Andrew said that the branded product has to be used on a very small number of occasions, but in the vast majority of cases, there is not a ha'p'orth of difference between the two products. Nobody would notice, apart from the packaging. That means that you are paying around £20 or £30 for the branded packaging. The beauty of the generic issue is that it is one of the few areas in which we can cut costs without affecting front line care at all. The only people who suffer are the Glaxos of this world.

I strongly believe that you should amend the contracts to tell GPs that they cannot use a branded product unless they can provide a strong business case for doing so to the Department. You should crack the whip instead of using the voluntary approach. It may have been appropriate, when times were good, to ask GPs nicely to do something. In the current economic situation, they must be told to do it.

Andrew, I appreciate and understand why you cannot extrapolate the Castlederg model to achieve £61 million. No one knew at the time that the Castlederg generic rate was below the Northern Ireland average. However, it clearly demonstrated showed that a vast amount of money was being wasted. If we work out what would be the optimum generic usage rate in Northern Ireland today and compare it with the present rate, the difference between the two represents money being poured into the Lagan. There is no excuse for wasting that money.

Given the present economic situation, why do you not simply start negotiations to amend the

contracts to tell Dr Smith or Dr Jones that they will adhere to the policy because the Health Service cannot afford to pay those costs anymore? It might save only £20 million, £30 million or £40 million, but that would go a long way towards the current £72 million shortfall without affecting anybody negatively. It is that lack of drive and determination that worries me. What is your response to that?

Dr N Morrow:

I am not an expert on GP contracts, but, as Andrew said in his presentation earlier, those are four-country contracts, and we are caught in a common contract relative to the rest of the UK. I do not disagree with your point. My view, as I said when last before the Committee, is that there is no excuse for not having an acceptable standard of good prescribing practice. It is the standards of practice that are important to prescribing, or pharmacy, practice. If the standard is that certain drugs should be used in certain circumstances, that should be established as standard practice. If we have a standard and someone falls below it, there would be consequences, and if they exceed the standard, there could be rewards. It cannot be all carrot: the whole idea of the philosophy of even incentive is that there are also sanctions.

Mr Wells:

There is no stick that the Department can use against GPs. It is all carrot.

Dr N Morrow:

I agree that we need compliance with the policy. Andrew's presentation and the briefing paper set out quite clearly that, for the reasons given, it is not possible to reach 100% compliance. We have talked to our colleagues in England. Their measures are slightly different, but, at the moment, their rate of generic prescribing is about 88%, which means that the prescriber writes the medication as a generic whether it exists as a generic or branded form. When translated to what is available when dispensing those prescriptions, England is sitting at about 66% against a target of 68% and struggling with that last 2%.

As of March 2011, our rate is just over 62%. The common understanding is that there is a threshold. In dispensing practice, that threshold appears to be about 70%. If we were to set that as the target, we would have another eight percentage points to go. That is what we should be targeting. It seems reasonable that we should require prescribers to relate to that target. In other words, we should do that where it is possible and does not jeopardise patients for safety or

clinical reasons. I have no difficulty with what you say.

The Chairperson:

Have you ever considered writing to GPs and telling them that, if they prescribe a branded product when a generic is available, they will have to pay the difference out of their own profit margins or — dare I say it — salaries?

Dr McCormick:

We do not have that power at the moment. We are signed up to a four-country contract, and prescribing has been part of the negotiations over the years. What we can consider is seeking further remit from the Minister that the Northern Ireland representatives at those four-country negotiations press harder for that to happen. However, the negotiation with GPs on the contract is highly complex, and it is locked into the need for the radical reform of primary care.

Look at what is happening in England, where the big picture in England is the Government's seeking to increase GPs' role in commissioning. We have some parallels with that here. England has a different model, but the large-scale savings needed across the water depend heavily on getting more primary care activity and stronger demand management for the Health Service. Demand management essentially means bearing down on the rate of increase in demand. Take basic economics: if price is zero, demand is infinite. The Health Service is free at the point of use. There is no limit, so nothing puts a pressure on demand. In crude economic terms, none of us hesitates to seek help because it is free. In England, the Government are taking new measures to try to bear down on demand to try to ensure that GPs play a more active role in that area. Of course, that is exactly what GPs want to do. That will be England's main focus in the negotiations on GP contracts this year and next year as they move towards the Government's 2013 deadline for the radical reform of the Health Service across the water. Alan Milburn, a former Labour Health Secretary, said that, if they do not do that, they will not achieve the £20 billion savings that they need.

We need the GPs. They are key players in many aspects of savings across the entire spectrum of health and social care. We have to recognise that it is right to try to do a deal that makes sense across the full spectrum of issues. There is every reason that the negotiations should take a strong line. The point that everyone makes is that, in the vast majority of cases, there is no good reason not to prescribe generically — save for the exceptions that we mentioned. There is a case for

greater sanctions, but it is part of a much more complex negotiation. We could go it alone.

The Chairperson:

The issue of bearing down on demand applies not only to the Department of Health, Social Service and Public Safety (DHSSPS) but all Departments. It involves exercise, keeping well, fuel poverty and equality issues, such as investment in children and young people. There are many areas for which every Department has a responsibility to ensure that people are well and do not require the services of GPs and clinicians. That, along with good preventative medicine and proper screening processes, will bear down on demand.

I do not want the whole meeting to be about potential pharmaceutical, because it has been obvious for a long time that "smarter procurement", to use your words, might be a good yardstick for examining other services in the Health Department's bailiwick. I do not know, for example, of any in-depth consideration of procurement policies in the Fire and Rescue Service and how savings could be made there. A worthwhile exercise might be for someone to inspect that service's books over the past number of years to find out where money has been spent that could have been avoided. I am not talking about stopping investment in appliances, because when Belfast is finished with its shiny appliances, we in Tyrone and Fermanagh get them, by which time they are battered and their windows are broken. Belfast gets the appliances that are sent out to be stoned, and we get them afterwards. I know that I am being facetious, but the quality of appliances is a serious issue.

This morning, I passed an ambulance that was sitting at the side of the road with its bonnet up. The two paramedics looked very embarrassed. One ambulance had broken down, and another vehicle had been sent to help. We want quality appliances on the road. I hope that no one was in the back of that ambulance, but I did not have the time to stop and find out. None of us want to see that, and driving past an ambulance in that state is not a great confidence boost.

We want investment, but we also know and understand that, at times, money is spent on things that are of no use. Robust procurement processes are not put in place, and I would like to see a bit more detail on how money could be saved in other areas.

I am sorry, Kieran. You indicated that you wanted to ask a question a lifetime ago, but I got carried away.

Mr McCarthy:

Thank you, Chair. Catherine, under the heading of service redesign, the briefing states:

"Trusts have plans for significant service redesign".

You go on to say that such redesign includes a:

"move from residential to domiciliary care".

Andrew also mentioned that briefly. You mention the problems caused by the lack of provision of domiciliary care. It seems to me that, under that heading, you are almost taking a gamble with people's lives. In other words, you will get people out of hospital as quickly as possible but not guarantee them sufficient aftercare. That is of great concern to me. Will you describe to the Committee what the state of play is at the moment? Are vulnerable people currently being moved into the community without adequate domiciliary care?

Ms Catherine Daly (Department of Health, Social Services and Public Safety):

As Andrew said, the information required is at a very high level, and there are issues for which the level of detail still needs to be determined. We need to be clear that any of the trusts' decisions to live within budget are taken in the context of their statutory duty of care and quality of service. Decisions will be taken in that context with due regard to patient care.

Dr McCormick:

There are pressures on the budgets. The model of residential care mentioned in the briefing paper relates particularly to elderly adult social care. It is not a matter of transferring people arbitrarily or hastily from a hospital setting to home. Discharge from hospital is always a matter of a clinical judgement on whether a person is fit to go home and whether the appropriate support package is in place. Those issues are quality managed, and no one will be put at risk. The risks are totally managed, and care is being provided properly.

The aspiration is to move much further in that direction and keep more people safely and properly cared for in their own home through a domiciliary care model and a reablement model. Again, that links to the minimising of demand. If people are suffering from a long-term condition and have acute episodes, the sooner that is picked up and the sooner the intervention takes place, the fewer times they will have to go into hospital. All of that is good practice. However, that requires more resource in the primary care setting in conjunction with good social care. We depend on the full spectrum of people working in those areas. It is an extremely important

model. At present, the budgetary situation makes the building up of the domiciliary care side challenging, but it is clearly the right thing to do as far as what people want is concerned. I assure the Committee that there is proper quality and good judgement to ensure that people are looked after properly.

The Chairperson:

Surely domiciliary care is much cheaper to provide than a hospital bed. Sorry, Catherine, had you finished your point, or had you more to add?

Ms Daly:

In most cases, domiciliary care is much cheaper. The key issue is that, in providing that quality of care, we get value for money in the most cost-effective way. The Minister will consider that as part of his strategic view of the provision of services over the next four years.

The Chairperson:

Although we are pressing you on savings and spending money wisely, we must bear in mind that some of our most vulnerable people are within four walls for 24 hours a day, and the person who comes in might be the only human contact they have during that time. That person is given a set time to prepare a meal, light a fire or prepare somebody for bed. We should not lose sight of that social element.

Mr McCarthy:

I am reasonably satisfied with what was said. I hope that it transfers on to the ground and that, as the Chair says, vulnerable people are not left to their own devices.

Under the heading of cost pressure rescheduling, the paper refers to potential savings of £10 million in mental health and learning disability resettlement. We all want the recommendations in the Bamford review and the 'Equal Lives' report to be implemented. Will you explain what that resettlement means for people with mental health problems and those with a learning disability?

Ms Daly:

There is no change to the general policy. As we explained earlier, the savings that we identified are one-off savings and will not happen every year. It is a timing issue of when the resettlements

that can take place and what had been factored into our budget: £10 million of that will take place at a later stage so, effectively, that is a timing difference.

Mr McCarthy:

Are any people suffering because you are trying to squeeze £10 million out of the budget for learning disabilities, the implementation of Bamford and all that goes with that?

Ms Daly:

No. It is not a cut in services as such. When I say that it is simply rephasing, I do not mean that in any trivial way. However, it is rephrasing; not a cut.

The Chairperson:

Anyone with mental health problems or a learning disability should be promptly and suitably treated in the community and no one should remain unnecessarily in hospital. However, that is not always the case. People are still living in long-term residential care who could be looked after in the community but, for various reasons, are not able to be. Is that the case?

Ms Daly:

That is the case at present.

Dr McCormick:

The issue is very challenging. For example, last year there was a major Public Accounts Committee (PAC) hearing on learning disability, and, at that stage, we acknowledged the difficulty with mobilising and maintaining the right programme. Northern Ireland has been behind other jurisdictions in this area in dealing properly with people on the Bamford Equal Lives principle, and that is not at all easy to defend. The issue now is to find the best way forward in the present context. Although we have a resource constraint, we also have a commitment to provide betterment for those people who have as much right to that as the rest of us, and it is very important to view the issue in those terms. Nevertheless, in practice, it is difficult to do.

The Chairperson:

Has the Supporting People project failed? Is it not working? Rephasing sounds the same as putting something on the long finger. I was on the Committee for Social Development when Supporting People came into being, and at the time, I had concerns about how it would work. I

know that people who need Supporting People packages are scundered — for want of a better word — as a result of not getting the right support and help from their social worker, or whoever. Those packages do not seem to be available for the people on the ground who need them.

Dr McCormick:

Again, there are problems in our budget, and other budgets, but we are working with the Department for Social Development (DSD). The basic model is strong and, when it is applied properly, successful. The objective is to make sure that it can be applied systematically and faithfully to all appropriate cases. I have visited some very good examples in which it is working. There is good accommodation and support, and there is partnership between the health and social care sector, DSD and its agencies, and the voluntary and community sector. Although there are good models, some are expensive because of the need to provide extensive care for people with complex needs. Society, however, has a responsibility to do that. We have to be creative and thoughtful about how to move forward, because that set of issues is challenging.

Mr McCarthy:

Of course we support what you are saying, but with reference to Muckamore Abbey, for instance, a number of people wish to remain there, for their own reasons, and I hope that you are aware of that, because it is important that those people are not just chucked out.

Dr McCormick:

I was sitting in this very seat when the Public Accounts Committee pressed me on that point. As I said then, no one will be forced to do something that they do not want to do. The professionals believe that everybody could have a better life in a context outside hospital, but each individual needs to be dealt with on a case-by-case basis. Each of those people has rights, needs and opinions, of which we need to be respectful.

Mr McCarthy:

I am grateful to hear that. Thank you.

Mr McCallister:

I will return briefly to generic prescribing. The last time that you were a witness, Norman, you gave me a rough figure of 72% as being the upper ceiling, although I accept that that was a fair guess. You are now saying that the threshold is roughly 70%, so you have 8% to gain. Having

gained a 3% or 4% rise over the past five to six years, are you confident —

Mr Wells:

Those are percentage points, John.

Mr McCallister:

Percentage points?

Dr N Morrow:

I am glad that I got that right.

Mr McCallister:

How quickly can you get to the maximum point stage? Jim made the point that such savings are easy pickings because they have no effect on care or front line services. How quickly can you get to that point?

Dr N Morrow:

We anticipate that we could move to another four percentage points and make that the kind of target that we want to achieve within the next year or so. At the same time, the permanent secretary and I have been talking about more direct communication with the service in order to emphasise strongly that not only does the Department want this as a matter of policy but the Committee wants it as a matter of good practice. It is about putting our foot on the pedal and keeping it there.

Mr McCallister:

Will it take a long time to reach that 8%?

Dr N Morrow:

If we move at a rate of 4% per annum, I would like to think that we could achieve it within the current comprehensive spending review (CSR) period, and then we will be where we need to be.

Mr McCallister:

Within the CSR cycle? We will definitely hold you that one. It makes sense.

Kieran made a point about residential care. Are many people currently waiting for care packages across Northern Ireland? I know that the figure varies from trust to trust.

Dr McCormick:

It varies from trust to trust. There have been some —

Mr McCallister:

The Chair touched on the issue. It is a crazy situation when attempts are being made to move people out of hospital without there being an available package for them. That is not an option for anyone.

In your paper —

The Chairperson:

I wonder whether we can get a list of the people who are currently in that position and are waiting to be resettled. We may discuss that issue in closed session, because I am conscious that there are sensitivities. We do not want to be in a position of saying anything that we do not want on the public record.

Given that this is a Programme for Government target, we do not have a sense of it being a priority for the Department, which it should be. However, that is not the message that we are getting.

I am sorry for butting in, John, but I think that it is important to emphasise that. We need to know more about the circumstances. We may need to press the Minister and his officials to ensure that those people's rights are dealt with.

Dr McCormick:

There are several dimensions to the issue. Some targets have been applied in the past number of years and are repeated in the commissioning plan direction that the Minister produced. It was completed on Friday and the Committee should have received it today. We should distinguish between the learning disability hospitals, for which a target is set in the new direction for 2011-12. That target is to resettle at least an additional 45 long-stay patients, compared with the figure at the end of March 2011, from learning disability hospitals to appropriate places in the

community and also to resettle 45 long-stay patients from mental health hospitals. So there is resettlement from learning disability hospitals and mental health hospitals, and there is also the wider issue of ensuring that we build up the domiciliary care side.

From the social care side, we must ensure over time that more people have care in their own homes rather than in residential homes. The long-term trend is that residential homes for elderly people are in decline, fundamentally because of what people want. Also, for economic and social reasons, it is right that more and more elderly people are cared for in their own homes. That is the third dimension.

The fourth dimension is discharge from hospital and ensuring that we have good discharge planning. That links in with the target for A&E —

The Chairperson:

We know the difference, and obviously discharge from hospital and the bed-blocking situation is very fluid. We know that there is a separation. However, we want another session on issues that relate to Bamford and the resettlement of learning disability and mental health patients. Given the sensitivity of the matter, we will do that in closed session. However, we need accurate information about how that pathway has gone so far, the outcomes of the work to date and the people who are still in those institutions.

Mr McCallister:

You talked about income maximisation and trusts maximising contributions from their clients for a range of services, such as car parking and meals. Is there any scope for improving, for example, the rate of claims back to the Health Service from car insurance companies? Is that ongoing? I know that that affects the Health Service and the Fire and Rescue Service. Can such issues be considered?

Norman, it is the Minister's view that 500 pharmacies is too many. Would you like to comment on that? Is that part of the Department's efficiency drive? How will you manage that?

Dr N Morrow:

I noticed that the Minister said that. That is an issue for the Minister, which could impinge on the issue that you talked about in the earlier part of your meeting.

The Chairperson:

Does that answer your question, John?

Mr McCallister:

Not especially. Maybe Andrew has a comment.

Dr McCormick:

I will comment on legal costs and reclaiming costs that are incurred. We have been through a large range of issues with the Minister's team, his special adviser and the Assembly Private Secretary. We had a long session, and we are looking at this issue again to find out whether there is any scope to ensure a faster, more efficient return of money due to the Health Service from claims of that nature. We are actively lifting every possible stone and trying to find every possible source. It is an exhaustive and ongoing process. I assure you that that is being looked at and being taken very seriously.

Mr Durkan:

A lot of issues have already been covered. However, I want to talk about the arm's-length bodies. At a previous meeting, we spoke about £32 million being secured from those bodies. That figure has now gone down to £28 million. Is there a breakdown of where that £4 million has gone? I know that it is due to inescapable pressures, but where exactly were those?

A table in the briefing paper lists programme costs as being £19·5 million. I presume that those programmes have already been identified. If so, how so? Organisations and projects have already come to the Committee to say that their funding has been withdrawn. I imagine that we will get a lot more of that. How was that assessment carried out, particularly given the excellence of some of those projects and the long-term savings that they provide for the Health Service?

Ms Daly:

Maybe I could answer your first question. The change in the figures from £32 million to £28 million is due to the overall budget assessment. In the proposals that we put forward to the Minister, we looked at the minimum possible level of need across the budget period, and allocations were proposed on that basis. When we got figures from the other bodies, some matters were simply not deliverable for statutory or contractual reasons, and the estimate had

been too high. Of the overall proposed reductions — I should say that it is not a reduction but a funding gap across the budget — £28 million of that is falling to those smaller bodies. The remainder of the shortfall is being met by measures proposed here and measures across the Health Service that the Minister is considering.

The Minister is still considering the detail of the measures that will be taken to deliver that £28 million; some fall into the categories that Andrew spoke about earlier. At this point, it is not possible to give details of the individual areas. In some areas, there may be policy changes on which the Minister has not yet made a decision. We will supply that information as soon as we have it. I hope that that clarifies that the £28 million that will be delivered from smaller bodies is deemed to have less impact on front line health and social care services. The remainder will come from other areas and across health and social care services in general.

The Chairperson:

We have all striven to be constructive and work with the Department and the Minister. However, it might be more useful to us to hear the Minister's thinking on that before his mind has been made up because we might want to influence him on certain areas rather than being presented with a fait accompli. It would be helpful to discuss issues while they are still work in progress rather than not having an opportunity to influence in any way.

Dr McCormick:

We are at a stage of the year when we need to proceed with a range of changes. As Catherine said, the objective is that those changes will have a minimum impact on front line care. Everything in the briefing paper so far is broadly of that nature. As the Minister makes decisions, we will be able to disclose further information. However, that takes us to a place in which the gap is only reduced to £72 million

Other issues, including John's points, are looking at the means to bear down on that £72 million. I can hear the passage of time because we have to find £72 million, not over 12 months, which would have been the case if a savings plan had been authorised before the end of March, but over nine months if it starts on 1 July — this Friday — over eight months if it starts on 1 August, and so on. Therefore, £72 million over eight months is worse than £72 million over 12 months; if the changes take effect on 1 October, it is over six months. So time is of the essence. The later any changes are left — savings, charges imposed or, at worst, challenges to other

Departments — the worse the situation.

The Chairperson:

We would have much preferred to have had an in-depth discussion a fortnight ago when we asked for it rather than having to reschedule this session.

Dr McCormick:

I am very sorry about that.

The Chairperson:

I do not mean to go back over old ground, but we recognise the time issue. In the table to which Mark referred, headline details take up about one third of the page. The DHSSPS programme amounts to £19·5 million, and that is just one line on a page. Although the table appears to give us detailed information, it is detailed information on small amounts and a big chunk that is not explained.

Dr McCormick:

Would it possible for Norman to slip away at this point? He has another meeting.

The Chairperson:

Yes.

Dr N Morrow:

If I could be released, Chairman, I would be grateful. I remain available to the Committee should you wish. Thank you very much.

Dr McCormick:

May I say a little about the £19·5 million? The largest programme budget for which the Department is directly responsible on the recurrent side is investment in the training of professional staff. A number of significant options in that area are under consideration and are currently with the Minister. The Department carries some of the cost for undergraduate and postgraduate training of professional staff. It is a partnership model with the Department for Employment and Learning (DEL), and the vast majority of student support is with DEL. We contribute significant bursaries for nursing, allied health professionals and dental students. Those

are some of the areas that under consideration, and I cannot pre-empt what the Minister may decide or announce. They are being considered to find out what scope there may be to balance the budget in a context in which there are many pressures. The rate of applications for those courses is quite high, so we have a good supply of people who enter training. The issues are much more about sustaining the delivery of services.

We have to look at the balance. I have discussed those issues with both vice chancellors. We need to look ahead and ensure that our future workforce is recruited and trained and that the training is maintained. All those issues are vital because, fundamentally, the whole service depends on people. We need to look at that area to see whether there is a way to bear down on costs. We are trying to get a bit more, but that is subject to the Minister's decision.

The Chairperson:

That is my point, Andrew. You are now hinting at some of the areas in which there might be savings. This Committee is charged with scrutinising the work of the Department, so we need all options on the table. I do not know, for example, whether you invest in pharmacy training, but it is my understanding that we train a whack of pharmacists, and we do not have posts for them. We are exporting young people who are trained up in a certain area. I imagine that pharmacy is an expensive degree, yet we train considerably more pharmacists than we need. We need those options on the table so that we can guide the Department on where we think that good sensible options that could be reduced can be looked at, while protecting and maintaining front line services.

Dr McCormick:

I assure you that there will be more than enough opportunities for that in the autumn as we move into —

The Chairperson:

When the decisions have been made.

Dr McCormick:

No; let me finish. The financial challenges for 2012-13 and beyond are of another, more difficult order of magnitude. Lots of options will need to be explored. We are very short of time for decisions and implementation in 2011-12. I apologise that I am unable to say more at present. If

issues are discussed in public session, that can start more things running than is helpful. I want to be as helpful as I can to the Committee.

Although the briefing paper is signed by Catherine, it is on behalf of, and with the authority of, the Minister. That is the information that the Minister approved for release. At this stage, it is the best that he was willing to give for the Committee. He has his reasons, and we are working with him on a way forward. There may be more that can be done, possibly in closed session. More will need to be done for the years ahead. I am sorry; at this stage, it is hard to say more. I want to be as helpful as I can as we talk about the broad areas, but I would not want inadvertently to hint at a decision that the Minister may or may not take on some areas.

The Chairperson:

Again, I do not want to labour the point, but we are getting the information only because a journalist made a freedom of information inquiry. Only for that, we would not have the information. Mark, you are not finished yet, are you?

Mr Durkan:

I cannot remember where I was. I accept what you say about arm's-length bodies and the perception that that is not affecting front line services. It was the mystery surrounding the programme — the £19·5 million — that caught my attention first. The idea is that £2·3 million will be taken out of administration. Although administration is not seen as front line, cuts in administration will certainly affect front line services.

I was actually in the A&E department of Downe Hospital yesterday for five hours, and I think that the doctor saw three people. He was at a computer taking notes the whole time. Taking money out of administration definitely has a knock-on effect on front line services.

The Chairperson:

A point was made during an informal meeting last week with the Royal College of Nursing: if nurses were equipped with the technology to help them to do their job — for example, if they had a laptop or an electronic device rather than having to go home to write things up — they could do the paperwork as they did the job. That information would then be dealt with much more quickly, and we would get better value for money from our nurses, especially in the community when nurses are in people's homes and not beside a computer. There are ways in which we could

invest to save, and the Committee could probably put some creative ideas to the Department to try to get more money out of Sammy to invest in helping our front line staff to do the right job to the best of their ability in a more effective way.

Ms P Bradley:

As Mark said, nearly everything has been asked. Although I could talk about domiciliary care for hours, I will leave that for another day as that issue has been exhausted today.

My question follows on from what Mark said about workplace productivity. Your paper has a proposal to reflect a greater skills mix, which is a wonderful idea. There are professionals out there, who, as you said, can only do the thing that they do, whereas other people could do the other tasks that need to be done. Therefore, a greater skills mix is definitely the way forward in trying to save money.

You paper also suggests that the trusts hope to make further savings by:

"suppressing vacancies on a permanent or temporary basis".

Will those vacancies be suppressed permanently or temporarily? Are the trusts telling us that they no longer need to fill those vacancies and that they have enough people to run our services effectively? Mark just told us about his wait in an A&E department and various vacancies in the trusts that have been filled with temporary rather than permanent staff during the past year or two. Do the trusts now believe that those temporary staff are no longer needed and that permanent staff can work at a higher rate of productivity to cover for them?

Dr McCormick:

Part of what happened is that posts that were held vacant on a non-recurring and rotating basis over the past year are now being permanently removed. That requires the type of approach that you indicated, and it is an important part of what is happening. The essence of that change is to ensure that when posts come out, it is still possible to deliver services properly, and it links into the range of efficiency and productivity initiatives.

Ultimately, saving money partly depends on making better use of existing staff in a proper way. There will always be a need for some temporary posts to cover absences, and so on. However, the trusts have had to be rigorous and smart about that kind of process in the past year, which is why there have been some job losses and posts suppressed and why some people have

not been replaced. There is plenty of evidence of concern about that in some sectors, and it needs to be done thoughtfully and carefully. More of that will be needed going forward, because the Minister will want to ensure that everything possible is done to avoid the need for redundancies and all the costs, difficulties and human angst that would result from that. We are trying very hard. The current numbers mean that we are facing a big challenge, but every effort will be made to manage that process as well as possible.

The Chairperson:

This will maybe sound worse than it is meant to. In the House yesterday, the Minister spoke about a review — I think that it was into security arrangements at the Belvoir Park site — when it seemed clear that a letter to the arm's-length bodies would be much more effective and helpful in giving them clear and unambiguous direction. The Committee earlier discussed the fact that there are plans to review human papilloma virus (HPV) screening, and it will write to you formally about that. Why is there a need for a review?

There seems to be an obsession with reviews and trying to cover people's backs, and it is an incredible waste of money. When I was the Minister of Agriculture and Rural Development, I saw that money was being spent on consultants when my officials just did not have the confidence to do the work themselves. Therefore, I lowered the threshold for the use of consultants to zero, and anyone who needed to use a consultant had to convince me of the merit of that. I can tell you that the list got considerably shorter.

Andrew, I am not trying to teach my granny how to suck eggs, but it seems to me that there is a wee bit too much farting about. That is not very parliamentary language, but —

Mr Wells:

"Messing about" may be better.

The Chairperson:

Yes; thank you, Jim. Andrew, the use of reviews seems to be off the Richter scale; it needs to stop.

Dr McCormick:

The HPV issue will require proper consideration, and we will get back to you as quickly as we

can.

The Chairperson:

There will be further consideration? The screening committee has already considered the issue.

Dr McCormick:

The background to the issue that was talked about yesterday in the House is that there is strong guidance in place. I issued a further letter on procurement practice to the chief executives of all the arm's-length bodies on Monday. So at one level we have done exactly what you said, which is to issue clear guidance. However, there are times when I, as the accounting officer, need additional assurance that guidance is being applied because we have discovered that, despite there being clear guidance, there have been lapses in practice. It is not about covering backs. It is about ensuring that guidance is being applied effectively.

The Chairperson:

Do you do spot checks?

Dr McCormick:

Sometimes a random check is the right approach.

The Chairperson:

Are there sanctions if a spot check throws up anomalies?

Dr McCormick:

Yes, there are. We would increase the pressure on the organisation concerned. Again, there have been examples of things going wrong in the past, and that has lead to — much like your approach to consultancy — our reducing delegations and requiring people to make cases more strongly. If arm's-length bodies are not fulfilling good practice or complying with the rules, we will address that. In the case of one arm's-length body, we had to withdraw a lot of the delegations to it as a result of an incident. We apply strong and effective governance to the arm's-length bodies. We do not do reviews for the sake of it. We do them if there is a good reason to investigate a particular issue in a short, sharp way, so that lessons are learned and we can move on. It is not about perpetuating that kind of culture.

The Chairperson:

With respect, Andrew, the HPV ones got six months and are coming back on 31 December. That is not short and sharp in anybody's language.

Dr McCormick:

I do not know the details of that.

The Chairperson:

We do; thank God.

Mr Dunne:

I want to take you back to our last meeting a fortnight ago. I have my notes here from that meeting. I understood from your presentation that time that you hoped to find efficiencies of between £60 million and £80 million in-house.

Dr McCormick:

In the trusts.

Mr Dunne:

Yes, in the trusts. You have now moved that on. Is that correct?

Dr McCormick:

I mentioned that £80 million again earlier on. It is the same £80 million.

Mr Dunne:

So the £72 million today is the balance?

Dr McCormick:

Yes; £72 million is the total uncovered gap on our present best view. If everything that is currently planned and proposed to manage the budget in 2011-12 happens, if everything works and delivers and if people comply with their budgetary thresholds and limits, including the trusts delivering their £80 million, there will be an outstanding £72 million, which we cannot see a way to cover yet. So we are working on a range of further ideas to find ways to close that gap.

Mr Dunne:

At the previous meeting, you said that £177 million was the minimum needed. Are you now saying that you can get that down to £72 million?

Dr McCormick:

We think that there are ways that that can be done. Some of the measures are still under consideration and are subject to formal sign-off by the Minister, so they could change the level of detail, but in broad terms, you are right. We had £177 million through a combination of some interventions, some things turning up the right way and spending on other things being delayed. We can get down from £177 million to £72 million, but it depends on a lot of things working out.

Mr Dunne:

Those savings really are significant. Are there issues still to come of which we are not aware?

Dr McCormick:

There is still some detail. Again, I apologise that we cannot give more detail now, but we will do our best to provide further detail as soon as possible.

Mr Dunne:

I understand. I have just one other question. Smart procurement was mentioned, which is an issue that large Departments have bandied around and worked on for years. I had some experience of that myself in a previous job. Will smart procurement be new to the Health Service?

Dr McCormick:

By no means. There have been many procurement initiatives over the years. Two organisations in the sector are centres of procurement expertise (COPEs). They provide guidance and advice to the wider sector. Those two organisations are the procurement and logistics service (PALS) of the Business Services Organisation (BSO), which deals with goods and services, and the health estates investment group (HEIG) in the Department, which has COPE status for capital procurement. Both those organisations have been working on smart procurement in their respective sectors. They have been in touch with the good practice that is developed by DFP's Central Procurement Directorate. We require and expect the vast majority of procurement by any of the organisations to be subject to the advice, analysis and support of one of those centres,

either PALS or HEIG. There are a lot of good initiatives there.

Mr Dunne:

Is there further scope to pursue that?

Dr McCormick:

There is scope to pursue it further, and we are looking to make the most of all opportunities. For example, Francis Maude, at UK level, has sought to secure, in the current economic climate, the chance to persuade suppliers to renegotiate some contracts to reduce cost to Government and to use the sheer buying power of Government. The Health Service has enormous procurement expenditure, so we need to be smart about it. It is not always the case that doing things in bulk and at a regional level is best.

Mr Dunne:

What about drugs?

Dr McCormick:

Drugs are a big part of that. We make sure that the approach taken to the procurement of medicines and medical devices — all those things — is as smart as possible. I am sure that there is room for further work and development, but we take that area very seriously.

Mr Brady:

I will go back to the issue of generic prescribing. I agree with everything that members have said. I listened to Jim, and he is starting to sound like a real socialist. *[Laughter.]* Take that as a compliment, Jim.

Mr McCallister:

I do not think that he has.

Mr Brady:

Maybe in another life.

GPs putting generic drugs on prescription was mentioned. I think that the figure you used was around 88%.

Dr McCormick:

That is the English figure.

Mr Brady:

When it reaches the pharmacist, the dispensing rate is around 66%. I accept that there are certain conditions, such as epilepsy, whereby people can be stabilised on a particular brand name drug, but what liaison or relationship is there? Is that done in isolation, or is there regular contact between and liaison with GPs and pharmacists to come to an agreement or a level of uniformity?

Dr McCormick:

A good piece of work is being done between pharmacy advisers who work for the Health and Social Care Board and GPs to provide better information, to explain the opportunities and to make sure that everyone involved in the process from all different professional points of view is aware of both opportunities and constraints. Work is also being done on the application of a formulary, which would specify the range of drugs recommended for use in Northern Ireland. It is always changing because the market is very active, but a lot of good practice is going on.

No one has talked about our aspirations to go further. The scale of additional savings available is still material, and we must apply every possible effort. Even if everything were done ideally on the issue of prescribing, I doubt whether that would make a big dent in the £72 million; I do not think that that is the total answer by any means. Again, your points are absolutely valid.

Mr Brady:

Domiciliary care is another issue. We have read so much over the years: in 1990, we had Putting People First, and then we had care in the community. Much has been written about the issue, but it seems to me, and there is a perception, that the approach to domiciliary care is almost ad hoc. That has been my experience in working in the advice sector for many years and dealing with people, and even more so recently.

The Chair mentioned Supporting People. In the last mandate and in this one, I sit on the Committee for Social Development, and it seems that Supporting People could do so much more with relatively less money. I have come across cases recently in which there is almost a form of emotional blackmailing of families. Maybe it is too strong to put it in that way, but I have come

across cases from which it is very hard to dissociate your thoughts and in which people who may be regarded as bed blockers were put back into the community without a proper support infrastructure. That is worrying. In one case, someone who had a severe stroke was put back into primary care within weeks. A wife was waiting to go to Papworth Hospital in Cambridge for a major heart operation and was on oxygen. The first thing that I noticed when I went into her house were oxygen tanks. There were about 10 of them in the hall because she was on oxygen 24 hours a day. That should not happen.

There is a perception that the approach can be ad hoc and is about saving money. That perception needs to be changed. That is an observation; it is not really a question. However, the Department needs to address that because the percentage of budget that is put into social care is minimal compared with that at the acute and clinical end. It is all about good prevention and saving people, because the cost of a hospital bed is about £220 a day. That is not happening, and people need to be aware of it.

Ms Daly:

I will pick up on that point. I give you an assurance that the departmental focus is on joined-up policy and on looking at the links between the various policies in the Department and across other Departments. I take your earlier point, Chair, about the importance of joined-up working across Departments. Although it may not provide any comfort, while we are working to develop proposals to deliver within budget, the focus is entirely on the delivery of effective quality care within the available resources.

Mr Brady:

I accept that. However, that seems to be an aspirational position. That really needs to be put into practice. I take the point that much closer interdepartmental working and contact is needed, particularly on Supporting People, because it can be so beneficial for people who want to remain in the community. There are examples in my constituency in Newry in which Supporting People and sheltered housing have worked well for people who have come out of trust residential care. That model needs to be replicated.

Mr Gardiner:

Rather than being critical all the time, it is worth noting that the Southern Health and Social Care Trust area achieved and exceeded its target on the generic dispensing of drugs. So we record our

appreciation to the doctors and chemists in the Southern Trust area, which is in my constituency of Upper Bann. Well done all round.

Mr Wells:

I can see that in the 'Lurgan Mail' next week.

Mr Gardiner:

No, no. I do not go into the 'Lurgan Mail' every week, unlike you.

The Chairperson:

OK, Sam. That is nice.

Mr Gardiner:

That is a happier note to end on.

The Chairperson:

It is a positive note; that is good. I will be a bit less positive now. We were intrigued by the information on the potential reduction in the scope of services in the paper that we got a fortnight ago. We have gone from being intrigued to being bamboozled. It says:

"There is no 'National List', of such procedures, however, certain areas … like Croydon have a list which includes the following".

It also mentions:

"Effective procedures where cost effective alternative should be tried first (e.g. hysterectomy for menstrual bleeding)".

Maybe I am being a wee bit stupid, Andrew, but please tell me that no GP anywhere would send a woman for a hysterectomy as a solution to menstrual bleeding when there are alternatives.

Dr McCormick:

The issue is to ensure careful consideration. If custom and practice is to proceed with a certain procedure, that should be re-examined if there are valid alternatives. I am not sure that I can help you with the detail in the example, but the list is intended to illustrate the kind of concept that we are talking about. There are areas of the service, both here and across the water, where some things are being done that are not as fully cost-effective as they might be. I hope that the further points provide other valid examples.

The Chairperson:

They do. Tonsillectomy is an example, and thank God, we have not had any trouble with our children's tonsils so far. I know families whose children have been absolutely tortured and have had to take a couple or three days off a month every month for years because of problems with their tonsils. In those cases, a tonsillectomy is the only procedure that would deal with such problems. The number of days that the children have missed from school is incredible, and there have been times when I have felt that the procedure has been drawn out when a tonsillectomy earlier in the pathway would have been a better option than to put a child through that kind of suffering.

Dr McCormick:

The key thing is for that to be judged case by case. No one is saying that there would not be a need for clinicians to judge what the right thing to do is case by case. It is difficult to be hard and fast in any of these issues. There are probably areas in the service in which practice needs to be thought about and in which alternatives need to be considered more than has been the case up to now. That is an exercise that is worth undertaking, but we do not say that it is black and white. It is not that we rule out certain procedures entirely. On some procedures, the advice might go out professionally. That will be a matter for consideration by the professional advisers at regional level to give guidance on a pathway to the service. It will not be black and white; a particular context will always be allowed for, and we will not do anything that is not in the best interests of a patient. There are some areas in which the clinical evidence is not clear cut and in which a more marginal decision is needed, and that genuinely needs to be thought about.

The Chairperson:

That issue is under active consideration. When do you expect to have a list of the procedures to be included? I am sure that the Croydon list is only an example for today.

Dr McCormick:

The Croydon list is intended to indicate the type of area that is worth consideration. It will probably not have much financial impact in 2011-12, given the stage of the year that we are at. Therefore, it should and can be considered in more detailed discussions on 2012-13 and beyond. If there are some obvious exceptions, it is right to proceed, but those are relatively few. I undertake to provide the Committee with fuller evidence in the autumn on the options that lie ahead. I will keep you in touch on any immediate issues over the recess, as you asked me to do

earlier.

The Chairperson:

As no one else is jumping up and down to get in, I will call an end to this part of the session. As a result of the paper, we may want to put other questions to you in writing. Andrew, earlier we discussed the review that is being carried out by John Compton. The Committee is very interested in seeing the terms of reference, and, to give you a heads up, we may seek a meeting during the summer to discuss that with you. We will appreciate seeing the terms of reference as soon as you have them and they have been cleared by the Executive.

Catherine, Andrew and Peter, thank you very much. I hope that it will not be too long until we see you again. Enjoy your summer if we do not see you between now and the start of the next session.