Northern Ireland
Assembly

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT (Hansard)

Departmental Briefing on Comprehensive Spending Review Efficiency Savings

15 October 2009

NORTHERN IRELAND ASSEMBLY

_____

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

_____

Departmental Briefing on Comprehensive Spending Review Efficiency Savings

_____

15 October 2009

Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Dr Kieran Deeny
Mr Alex Easton
Mrs Dolores Kelly
Mrs Claire McGill
Ms Sue Ramsey
Mrs Iris Robinson

Witnesses:

Mr Sean Donaghy	)	
Dr Andrew McCormick	)	Department of Health, Social Services and Public Safety
Ms Diana Taylor	)	
Ms Julie Thompson	)	

The Chairperson (Mr Wells):

The next evidence session is on the comprehensive spending review (CSR). I welcome the departmental officials: Andrew McCormick, permanent secretary; Julie Thompson, director of finance; Sean Donaghy, undersecretary of the resources and performance management group; and Diane Taylor, for whom I do not have a designation.

Ms Julie Thompson (Department of Health, Social Services and Public Safety):
Diane is the human resources (HR) director.

The Chairperson:
That sounds very important. I remind members that we are to discuss the CSR efficiency savings. This will, naturally, overlap with earlier sessions, but I will try to keep Committee members to the subject. I will ask the permanent secretary to make a brief presentation, after which members can ask questions to the panel.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):
I thank members for their good wishes. I have returned to the job with a better appreciation of the quality of service in the Health Service.

The Chairperson:
I am glad to see you back.

Dr McCormick:
My experience was of personal significance, and tribute is due to the staff at the Ulster Hospital who did a very good job for me. I want to underline my appreciation for their help.

Sue challenged me earlier to return to my time at the Department of Finance and Personnel (DFP). As the Chairman said, I must respect the differences between the two Departments. I can outline issues that the Department of Health, Social Services and Public Safety (DHSSPS) knew about during that period, but I can speak only from the point of view of my responsibilities in DHSSPS.

It is worth considering how we arrived at this point and why the issues that we now face are so challenging. I will outline the background to the CSR. The work on the Appleby report arose from discussions between the then Secretary of State, Paul Murphy, and the then Chief Secretary to the Treasury, Paul Boateng, at the end of 2003.

The Treasury asked why Northern Ireland had the highest level of spending per capita yet the worst performance. The situation has changed radically since then, which is the point that I want to make. John Appleby was asked to explain why Northern Ireland had the highest level of

spending per capita yet the worst performance.

Since then, we have addressed our waiting-list problem through a major regime of performance management, which began before my time in the Department. We have seen that through with a consistent and strong approach so that the Health Service's standards and performance have been raised. Improving the management of the Health Service has been at the heart of much of our actions, and many people in the health and social care sector have applied immense effort to securing a better performance for the public in a range of areas, including elective waiting times and emergency care. We are also trying to ensure that there is a balanced approach and that we have movements across the full range of services.

Therefore, since John Appleby reported in 2005, there has been a significant improvement in performance, and there are statistics to back up that assertion. For example, in 2005, 14,000 people were waiting more than six months for surgery. There is now a tiny number waiting for that length of time, and we have targets for patients to receive surgery within 13 weeks. In 2005, we did not even measure the waiting times for diagnostic tests, but now we can deliver them within a good time frame for the most part. There are some issues, but we are dealing with them effectively.

The improvement is the result of a combination of work by managers and clinicians working together to deliver a better service. No one is saying that the situation is perfect, but compared with the situation a few years ago, it is night and day. There is a much better standard of performance, and we should pay tribute to everyone in the health and social care system who was involved in the delivery of that. We need to do more and secure further emphasis on a public health-led commissioning system that will secure further long-term change.

The other major issue that emerged from the work of John Appleby was the point about expenditure and need, which the Minister mentioned. Before Appleby's investigation, the Treasury asked why spending per capita was higher in Northern Ireland than in the rest of the UK. However, spending per capita in Northern Ireland is no longer the highest in the UK. For example, leaving aside expenditure on social services, our spending per capita on health alone is only 2% higher than the UK average and, as the Minister said, our need is 10% higher. Similarly, because of a pattern of societal need in Northern Ireland, our need for spending in social services is 36% higher than the UK average, yet the actual spend is between 10% and 15% higher per

capita than the UK average. We need a lot more money than that.

Those figures are based on evidence that was worked through in great detail following the work of John Appleby and was subject to peer review by some of the most authoritative academic commentators in the UK. DFP has not challenged the substance of any of those figures. As the Minister said, no point that we made on the issue has been challenged. We have an evidence-based approach that demonstrates the need for health and social care expenditure in Northern Ireland.

That approach was the result of a major piece of work that emerged from the Appleby review. Appleby set us some challenges on productivity, organisation, the review of public administration and how to progress. Through detailed work and analysis, we have followed up every aspect of his recommendations to ensure that we are delivering the best possible services and are as efficient and productive as possible. In a highly complex set of services, it takes time to achieve those targets, but we have the necessary leadership, management and commitment. There is a particular emphasis on working with the professional leadership so that we secure leadership from doctors, nurses, allied health professionals, social services professionals and all the other professional groupings. We need them all to take the lead to help secure the best possible outcomes for the public, because that is what we are about.

We have made significant changes since then. However, as the Minister said, it remains the case that the rate of spending growth of 4·3% that John Appleby recommended in a long-term context — not only for a few years — has not been possible with the Northern Ireland Budget position. At the outcome of the comprehensive spending review in January/February 2008, the Minister said that he had got the best budget that he could — it was as good as it gets. It was not enough, and that remains the problem.

We have to manage that situation. We must secure manageable change. We must ensure that there is a strong emphasis on making our services more productive and of high quality; there is no room for compromise on quality and safety issues. We must also ensure that we deliver the right standard of performance. Those are immense challenges, but the leadership teams across the organisations want to make those things happen to secure the best possible service. The Minister wants to secure the strong commitment of primary care in the commissioning process, allied with local government and the voluntary sector, to ensure that we have change that is locally driven

and is serving the needs of the community. That is the only way in which we will survive and the NHS system can be afforded.

In 2001, the Chancellor of the Exchequer asked Derek Wanless whether the NHS was sustainable. Derek Wanless said that it was sustainable if the resources were provided and the public engaged properly, with people committed to looking after their own health as much as possible and with a system in which we are not a Department for health services but a Department for health and well-being. We need to change the nature of what we are trying to do to secure that commitment. Derek Wanless said that there were major challenges to meet in order to achieve that. The Chancellor of the Exchequer increased National Insurance by 1% to provide that funding. A UK-wide tax was imposed. However, on the basis of the numbers that we have, it is not evidenced that that has been delivered evenly across the UK in respect of resources going in. It is clear that the Health Service in Northern Ireland has not had a fair share of that compared with the rest of the UK.

Derek Wanless was the Department of Finance and Personnel's first choice to carry out the review of health and social services in Northern Ireland. John Appleby was the person who stepped up to the plate to do it. We have sought to deliver the changes that were recommended and to see the positive changes coming out of the review, but the resource context remains very challenging, as the Committee is aware from all that it has heard today.

I hope that that is helpful, Chairman.

The Chairperson:

You will have heard the tenor of the previous hearing. We need two different phrases: efficiency savings, which is the 3% figure in the comprehensive spending review; and deficiencies, which is the present situation involving the contingency budget deficient plans. The Minister confirmed that the Department has now got those plans for how the shortfall will be addressed in the 2009-2010 financial year for all the trusts. We hear that the plans are for £70 million. Is that roughly right?

Dr McCormick:

That is the position on the basis of what the trusts have known up to this point. The Minister has just said that, as a result of the Executive's decisions this week, he has a firm budgetary position

for the first time since the swine flu issue arose. Detailed work is being done to examine the allocation of the money secured to deal with swine flu. We are also looking at what we can do about elective care, an area in which there are some significant funding issues. For example, Belfast Health and Social Care Trust has had to suspend the use of the independent sector for that purpose. That pause in the process has occurred because we have been financially uncertain up until now.

We also need to see what is to be done about the deficits. There are proposals on that, but none of those has been considered by the Minister, nor has anything been approved or agreed by him. We have the details, and we are working with the Minister on those detailed situations, knowing this week for the first time how we stand financially. That is a work in progress, and I cannot give the Committee detail on it now. There will be further detailed work done in the next few days, and the Minister will make the proposals clear as soon as is possible.

The Chairperson:

When will those proposals be published, and when will the Committee get to see them?

Dr McCormick:

That is for the Minister to decide. He will publish them when he is ready.

The Chairperson:

The difficulty is that, every day, the press are thrusting microphones in front of Committee members' noses and asking them for their views on the Belfast Trust's deficit of £25 million — it is now £23 million — or the Northern Trust's deficit of £27 million, or the Western Trust's deficit of £8 million. Clearly, that information is in the public domain, and yet the Committee has not seen the various trusts' proposals on how they intend to deal with the deficits.

Dr McCormick:

I understand that. It is the statutory duty of the trusts to break even. They have had to work on a contingency basis, because the budget has been uncertain up to this week and has affected their position. The trusts are saying that that is what they will have to do if they are held to the existing financial position. We now know that that will change as a result of the Executive's decisions. However, we are not ready to go into detail about that at this stage. The trusts have had to base their work on certain assumptions. However, as the Minister said, those assumptions will

certainly change. As soon as the position on the Minister's decisions is clear, we will be happy to come back and share that information with the Committee.

The Chairperson:

Implicit in what you said is that the news will get worse. For instance, is the Department thinking of spreading the £32 million to address swine flu among the five trusts?

Dr McCormick:

I do not want to give you that impression. We have had to recognise that there were significant uncertainties, and that meant that we had to keep some options open. Now that the Executive have made their decision and we know where we stand, certain measures can be put into place. The position will improve the work that the trusts have been doing. Again, I cannot really go into detail about that, but there will be further news in due course. The Minister will look at that very carefully.

The situation will be challenging because of the scale of the problems that the trusts face, and that goes back to the issue about the level of demand that they face. Significant issues will need to be addressed. However, the scale of the deficit will be lower than the £70 million that we talked about earlier.

Mrs D Kelly:

I have to leave soon to attend a parent-teacher meeting, for which I am late, so I apologise in advance.

Thank you for your presentation. What is the worst-case scenario if the trusts do not meet their efficiency savings? Will they all be declared bankrupt? What hit is the Department taking over efficiency savings? I do not think that I have yet seen a plan from the Department. I want to see one, so that I can put it into context with the trusts' plans.

The Health Service has always relied on goodwill and has never been costed. I pay tribute to health and social care workers across all professions for the work that they have done. As someone who used to work in the Health Service, I recognise the value of clerical staff freeing up professional staff to get on with their jobs.

This is a question for your HR representative. Surely one of the risks of restructuring social services teams and of downgrading them too much is that the profession will offer few development opportunities and little chance of career enhancement, and will therefore not attract people of any age to university or wherever to train as a social worker. Where is the workforce planning in respect of the acceptance of the skills mix? If the profession is downgraded too much, it no longer becomes an attractive career option.

Dr McCormick:

I will let Diane answer your third question, and I will answer the first two. There is an obligation to deliver efficiency savings. That is part of the task of securing a balanced budget, which is an obligation on all the organisations. The trusts have to secure efficiency savings, and the Minister has said that they will do that. It is very difficult, but it must happen. With that, there will be an unacceptable underspend. That is fundamental to the way in which public finance works, which is point that we talked about earlier.

As far as the Department's budget is concerned, all Departments are required to deliver 5% a year reductions in their running costs, so there are specific challenges for us in that each Department has to manage its running costs by looking at its priorities to ensure that it carries out only the functions that it is required to provide.

There has been a major change in the past year owing to the creation of the new organisations under the review of public administration. Some functions have moved out. However, even having done that, we face a significant budget challenge, which means that we must ensure that we are focusing on what matters most. We have to deliver support to the Minister, as well as the analysis and strategy that underpin that support. It means significant reductions, but, because we are part of the wider Civil Service, it is a manageable process, given the levels of turnover and personnel in the Civil Service. It is a challenging process of prioritisation.

Mrs D Kelly:

Will we see a copy of the Department's efficiency plan?

Dr McCormick:

Yes, we can get details of that.

Ms Diane Taylor (Department of Health, Social Services and Public Safety):

Members may be interested to know that a workforce review of social services is about to begin. All the stakeholders who have an interest in social services will be able to offer input into what the future workforce should look like, where the gaps are, what the skills look like, and what the career pathway should be. A workforce learning strategy will be issued later this year. That will include social services and will demonstrate that there should be career pathways for staff involved in social services, right from the support grades of staff through to social workers and above.

Substantial money is spent on education, including both the pre-registration and postgraduate education of social workers, and that is under review. We have a knowledge and skills framework in place, which applies to all staff who are part of the Agenda for Change rates of pay. That will also help enhance careers and identify where there are skills gaps for those individuals.

Mrs D Kelly:

I take it that we will have copies of the terms of reference for the reviews?

Ms Taylor:

Those will be copied to the Committee.

The Chairperson:

Although we appreciate the announcement, we did not know about that until you told us.

Ms Taylor:

I appreciate that.

The Chairperson:

Unfortunately, this meeting and the BBC have been our main sources of information at the moment.

Mrs D Kelly:

Can we possibly have a briefing on that at some stage?

The Chairperson:

Even one page of information may be helpful. We are very conscious that we tend to be hospital-oriented and medically oriented in this Committee, rather than concentrating on the big chunk of work that social services do.

Dr Deeny:

You said that our health-spending need is 10% higher than elsewhere. Is that as a result of the deprivation that was measured?

Dr McCormick:

Yes.

Dr Deeny:

More or less. The Barnett formula used to be used, but I do not know on what basis deprivation is calculated now. I was very interested to hear Dr McCormick talk about the NHS and Mr Wanless's comments. I am a great believer in the NHS. I have worked in it for years, but I have recently wondered if it can go on, what with the increasing costs of procedures, medication, increasing demand and an increasingly elderly population. Healthcare free at the point of delivery is wonderful.

You mentioned resources and community involvement. Mr Wanless said that those are essential in order for the Health Service to survive. My area would correlate with the rest of Northern Ireland in that the provision of resources, and I know that "resources" is just one word, is a huge issue. We need that, big time. How do you see that working with community involvement? As a primary-care physician, I think that you must show the community that you are really serious about its health. If we are going to move a great deal of care responsibility into the community, as we are talking about, the equality that the Minister talked about in primary care centres across Northern Ireland needs to be there. We are not seeing evidence of that. That is on the back burner in my area.

The Department has to tell people that it is serious about this, and that it is going to involve them. Do you foresee that, Andrew? Local commissioning groups — I must declare an interest as a member of the Western Local Commissioning Group — and, below that, community care associations have to be involved. I would love to see the community getting involved in its

healthcare in future, I really would. However, you really have to send out the message to people, loud and clear, that we are serious about this.

People heard two years ago that new primary care centres would be built in certain areas. They have now been delayed and put on the top shelf. That sends the wrong message that such centres are no longer an option because of financial problems. What is your view on that matter?

Dr McCormick:

When the Minister set up the new structures, he put a much stronger emphasis, compared with the previous model, on the public health role in commissioning. That is the raison d'être for the new public health agency. Moreover, the Minister has given it the major task of working with local government and wider community and voluntary sector organisations to secure a different approach. Commissioning should not only be about securing the right to procedures in acute hospitals. That is a limited view of what needs to be commissioned.

A much wider view is necessary, and it requires partnership with many other sectors; public health is not, by any means, an issue for DHSSPS alone. Other Departments have vital and significant roles in developing the agency and making the necessary change in our society. Both Derek Wanless and John Appleby talked about what they called "fully engaged". They said that the Health Service would cost less to run if the community took more responsibility for its health and if the health and social care sector and other public services secured the right roles to promote health and well-being. That is the way forward, and there are major issues for all aspects of health and social care. We need to build on our position.

The agency was affected soon after its establishment: the swine flu issue arose and became an obvious and immediate responsibility for that group. Subsequently, we have been slower to make progress on some issues than we had hoped. However, the Minister remains strongly committed to making the agency work across the whole region and to securing engagement, buy-in and commitment to a new approach. Again, there are issues with the capital budget. The delays to the building of some facilities are unfortunate and difficult to manage. The most important aspect by far is to get the right people to work together to effect the changes. Only through doing that will society be able to afford the NHS. The UK Government, and Governments worldwide, faced that dilemma, and Barack Obama's number one domestic policy issue is to achieve affordable healthcare.

In order to sustain the NHS, we require the right measures, cross-societal engagement to promote public health and well-being, and recognition of the resource issues that we face. That is just the way that it is. If we want a Health Service that is free to use, we need to find a way in which to reduce demand. Demand has risen significantly, and we will only take the edge off that growth through better prevention. The report says that costs will be significantly higher if we do not take the right approach.

Dr Deeny:

Given the big-time shift from secondary care to primary care and community care across Northern Ireland, should the primary care centres of the future be prioritised again?

Dr McCormick:

Yes. The Minister has placed significant priority on trying to progress some of those centres. Several are contained in the programme; that is major part of what we are trying to achieve. There is also a responsibility to create safe and effective facilities in the acute sector. It is not always easy simply to follow the strategic priority; it is sometimes necessary to do what is unavoidable and essential. Balancing and managing those things is part of the challenge.

Mrs I Robinson:

First, a better Health Service, not a more expensive one, is desirable. Where did the £90 million-plus for the swine flu vaccine that the Minister refereed to in the House come from, when there is now a reduction of quite a few million pounds from what he projected that he would need?

Secondly, what engagement are you having with the private sector? You referred to Obama: it is about marrying the two definites of healthcare provision — the private healthcare provision and the healthcare provision that President Obama is trying to introduce, which will bring a more inclusive healthcare provision to people on low or no income. Can I play devil's advocate for a change? No one can argue with the figures that show that the budget for health has been the largest ever given during the life of the Health Service.

Enormous pressure was put on trauma units in our hospitals during the Troubles, and some of our surgeons in the Royal Victoria Hospital pioneered amazing efficiencies for dealing with trauma victims, which were shown across the world. Our consultants were seen as a leading

force in dealing with brain surgery and trauma victims. Now that we have relative calm and our hospital wards are not being filled with people who have lost limbs or who have received other horrendous injuries, why are we, allegedly, in this so-called mess? I am looking at the situation simply, and I stand to be corrected, but if the Health Service is not having to deal with the impact of that any more, thank God — although I understand that anyone who has been kneecapped or shot will have a lifetime of attention given the physical and mental-health issues that arise — why are we not seeing amazing savings in our healthcare provision? Perhaps I am dealing with the situation very simply, but when we do not have to deal with such horrendous injuries and have more money per head of population than ever before, there seems to be something dreadfully wrong if the books do not add up.

I reiterate what my colleague in the SDLP said earlier: I want to see what the Department is doing on efficiency cuts. We have seen what the trusts have to do. However, I will leave that question in the air, and perhaps it can be addressed.

Dr McCormick:

I will bring Sean in on the points that you made about the change in the cost estimates for swine flu. However, on the broader general point about whether the Health Service is becoming more expensive, and I understand the dilemma that you posed, the biggest cost factor driving that position is the ageing population, and that involves a greater increase in the cost of looking after people. Moreover, in what is celebrated as a system that is free at the point of use, there is a contract with the citizen to provide the best care available, which is to say that if new procedures or new drugs become available, and some can be extremely expensive, we have promised the public that we will provide the best that is available.

Those costs and needs are accelerating well above the standard rates of inflation. A situation across the UK in which both main parties are talking about major reductions in future public expenditure will create an immense dilemma.

The main parties have said that they are committed to protecting health, but that is because it is recognised, and there is a consensus across society in most parts of the UK that protecting health is vital. The costs are genuine: one of the witnesses who gave evidence earlier said that costs are rising by around a minimum of 3% just to keep pace. That is at the low end of the estimates that have been made. Having a health and social care system that is free at the point of

use dictates the nature of the costs in the longer term. That is what those major academic and economic commentators concluded after many months of analysis and research.

Having asked the question, "Is this really necessary?", the answer came back that it is — this is the real nature of society, and the costs arise from having an ever-ageing population. Thankfully, we are all living longer, and, as we do so, there are more chronic diseases that have to be managed, and that is becoming increasingly expensive to do. It outweighs the benefits of having a peace process that has meant that trauma levels are reduced. We have enjoyed the benefit of that for quite some years.

Looking ahead, there will be major cost increases, not to mention issues such as the birth rate and staff pay. Independent commentators have been brought in by the Finance Departments, commissioned by the Treasury in the form of Derek Wanless, and by DFP, who commissioned John Appleby. Those people did not have a vested interest, but they provided clear and well-argued evidence that showed that we have a real need to address the dilemmas that face society.

The model that the Minister is pursuing here does not promote a private sector solution. He is committed to public sector delivery of health and social care. That is what society wants, and it is the main solution. The consequence of that is that we have many obligations to fulfil that contribute to costs. However, it is seen as the right way to go for this society.

Those are the main points that I wanted to cover. I will ask Sean Donaghy to talk about the changes to the costs associated with swine flu.

Mr Sean Donaghy (Department of Health, Social Services and Public Safety):
It has been recognised for some considerable time that it is difficult to be certain about the potential effect that swine flu will have on society and the impact that it will have on the Health Service in coping with the disease, largely by way of admissions to hospitals and, potentially, by admissions to critical care.

The Scientific Advisory Group of Experts (SAGE), which advises the four nations, set those probabilities out and made it clear that there was a range of possible outcomes. SAGE could not be certain which level of clinical attack should be planned for. Through the Minister, this Department set out three possible scenarios, all of which depended on the level of clinical attack

and severity of illness that would result: one in which we anticipated that the cost might be approximately £64 million; one in which the cost might be approximately £77 million; and one in which we anticipated that the cost could be as high as £96 million.

In his address to the Committee, the Minister said that, in the context of getting to the stage at which we could have a clear budget that allowed us to go ahead and cement our preparedness for swine flu and also to know what the impact was going to be on the balance of our budgets, one of the points of agreement that was reached was that we would use the low-risk probability budget scenario and thus work to a budget of £64 million.

Elements of the cost do not change in all three scenarios. The costs of purchasing vaccines, antivirals, personal protective equipment and antibiotics are all constant, as is the sleeping contract to trigger the production of vaccines. The UK Government were one of the few Administrations in the world to have had such a contract in place in advance of the onset of swine flu. The key variability in each of those is, primarily, the extent of the impact on hospital care, and also the impact on primary healthcare. In that context, the low-risk-probability scenario is the one for which we have a budget. The actual impact of swine flu could outstrip that budget, but we are hopeful and optimistic that that will not be the case and that that £64 million will be sufficient for health and social care to meet the costs of swine flu until the end of the year.

Mr I Robinson:

I may have got some names wrong earlier, but the Minister was wrong to give a figure of £22 million on the Floor of the House. If £64 million is subtracted from £96 million, £32 million is left.

Am I correct to say that the Department has bought a vaccine for every person in Northern Ireland?

Mr Donaghy:

Yes, that was the advice that SAGE gave across the UK, and that is the position in Scotland, Wales, England and Northern Ireland.

Mrs I Robinson:

Given that there is a vaccine for everyone in Northern Ireland, why would the budget for swine

flu increase further? Kieran, close your ears, but who on earth thought of paying doctors £5-plus per vaccine that they administer, ad infinitum? That would be similar to my asking for a charge of £5 for seeing a constituent. I find the whole area strange. Many people are indicating that they will not take the vaccine, and they may change their minds only if things get bad. What is the likelihood that many of the vaccines will have to be destroyed? I assume that they have a use-by date.

I am listening to the debate from the perspective of an ordinary person, and I cannot get my head around the fact that, despite 40 years of terrorism, Northern Ireland had one of the best National Health Service provisions, and the hospital system was still able to deal with all the people who survived. There were 19 trusts and four boards, and that has been reduced to six trusts and one board. Years ago, people were in poor heath because, for example, they worked in the shipyards, exposing themselves to asbestosis. There was a poorer standard of living in those days, so the money that was spent then is comparative to what is spent now.

I see that you have done a little note or drawing, and I am sure that it is amusing.

Joe Public is wondering why, given that almost 48% of the block grant goes to the Health Service, those difficulties exist. I suggest that it is because the entire Health Service has become top-heavy. Jobs created jobs, and concerns such as health and safety have created a wealth of personnel and duplication. I want a good Health Service in Northern Ireland — that is what I am about — and I am sure that everyone here would say amen to that. It seems that you are throwing money into a bottomless pit, and Joe Public will say that. I am trying to get my head around why we are continually in the media talking about deficits. It does not add up.

Dr McCormick:

As you said, the position has changed radically in the past number of years. Part of the reason for the higher costs of providing health and social care is that more people are living longer. In the past, some illnesses and conditions lowered life expectancy. As the Minister has said, healthcare costs increase radically with age. That is how things are, and it is the biggest single factor underpinning all this.

On the issue of organisational changes, there has been a genuine, demonstrable reduction in senior management and in administrative and clerical numbers. I do not agree with what Dr

Brian Patterson is reported in today's 'Irish News' as saying — this is not about more bureaucracy. On the contrary, we have a much leaner management structure and are much tighter organisationally.

I pay tribute to people who work in those organisations, because they are under extreme pressure to try to deliver on a demanding agenda comprising safe and high-quality services, financial balance and high standards of performance. They are continually reminded of those demands by the Department and the Health and Social Care Board, which oversee and secure proper accountability, because another corollary of an NHS system is that we are publicly accountable.

In every aspect of what has been discussed, we can demonstrate in detail what we are doing and that management costs are coming down. Health is the only sector that has delivered the RPA changes so far; the other Departments are still working hard to secure their changes. We have endured a very demanding process of change through which the new organisations delivered improvements in standards. That remarkable achievement has happened in the face of rising demands on services and rising costs on the pharmaceutical and pay sides, because, as part of the same system, we are subject to UK-wide pay costs. All those factors apply. We can demonstrate that in full detail, and I am happy to expand on it if the Committee wishes.

The facts will bear out that we are delivering a better set of outcomes from our necessary budget, which provides only what is needed. The Minister is simply seeking to deliver health and social care as it is defined: free at the point of use and based on NHS values and principles. Independent evidence states that the budget being sought is necessary. Major economic commentators are saying that, for 20 years, year-on-year growth well in excess of inflation is needed to sustain health and social care as we know it. That creates a very extensive requirement for accountability to the taxpayer.

One of my most onerous responsibilities is to be the accounting officer for that large budget. I will be back in the Senate Chamber on 12 November to be scrutinised in that role. That is part of what it is all about. We are answerable, but that also means that there is a cost. In order to be publicly accountable, we must have the support and information to supply answers. In fact, by many benchmarks, we spend less than the Health Service in England on ICT and on management consultancy. Those are examples of expenditure for which we must demonstrate our public

accountability.

Mrs I Robinson:

I dread emerging from today's meeting with the sense that older people feel guilty for living longer. Given all the talk about assisted suicide, the frailty of the elderly and people living longer and becoming burdens on families, I do not want it thought that we are targeting older people.

Dr McCormick:

I could not agree more. We have a responsibility to provide services for older people.

The Chairperson:

There is a long list of questions for the witnesses.

Mrs I Robinson:

I did not get an answer to my point about the private sector.

Mr Donaghy:

I will try to answer that quickly. At one point, there was a suggestion that the Department should provide £22 million from its capital budget to meet part of the cost of swine flu. We were very pleased when the final settlement did not include that element. That may be the source of reference for the figure of £22 million. However, that was not part of the final agreement on the budget settlement for health.

I may not have been clear about the £64 million figure that I mentioned. The cost of vaccines, antivirals, personal protection equipment and antibiotics is constant and does not change with each of the three scenarios, for the reasons explained. Those are constant costs. What changes are the costs of treating people who suffer from swine flu, depending on the numbers who become ill.

The Chairperson:

You are provisionally due to appear before us again on 12 November, is that correct?

Dr McCormick:

I will be appearing before the Public Accounts Committee.

The Chairperson:

My difficulty is that everyone wants to speak to you. You are obviously the hottest ticket in town. However, at the present rate, we will finish this meeting at 6.00 pm.

Mr Donaghy:

I will finish by saying that the figure of £5·25 was negotiated nationally by the Department of Health in London on behalf of the four nations.

The Chairperson:

With the same trade unions that negotiated the gold-plated GP contracts.

Mr Donaghy:

The very same.

The Chairperson:

I wondered why it was so generous. I wish I had those negotiators. I will try to conclude this session fairly quickly; otherwise, it will go on and on. There is still a great deal of business to conclude after this evidence session.

Ms S Ramsey:

I know that your patience is wearing thin. I have a number of questions, but I would be happy to receive written answers from the Department to some of them. We have been at this all day. There is, allegedly, a crisis, and everybody and their granny is talking about the health sector. Some of my questions are aimed at teasing out some information.

Andrew, you said that it is not only about promoting health and well-being but about better prevention. I totally agree with that, but we need to put to bed the myth that it is as easy as taking money from another Department or another budget to give to the health budget, as has been said today, and constantly over the past few months. All other Departments have to play their role in promoting health and well-being and prevention, whether in leisure, employment, education or housing. It all leads to good health. That is the theme that should be expressed. It is not as simple as taking money from some other Department and giving it to DHSSPS. If we are going to politic on the issue, we need to be big and ugly enough to hear politics back.

When you speak about the pharmaceutical delivery plan and the savings in the community and the hospital over the three-year period, can you provide a copy of how that is broken down across trusts? You can send that information to me.

My other question is about generic prescribing. I would like more information on the regional tendering process that you mentioned, because I am concerned that pharmaceutical companies have it sewn up, and we are being held as soldiers of fortune. I am happy to see the proposal for generic prescribing, but I want to know what the Department is doing on that.

For the record, I will quote what the pharmaceutical delivery plan says about the equality impact assessment (EQIA):

"The proposals are all designed to improve the service response to need and to release resources which will be available to finance new developments."

That is not the negative message that I am hearing from the Department. It goes on to state:

"The S75 equality groups will be major beneficiaries of the redesigned services and new developments and in that regard the assessment is that the proposed measures will impact positively on the equality groups."

That is not what I am hearing. I am hearing that there are cutbacks that will affect the elderly, children, the disabled and people with mental-health problems. They are section 75 groups, so we need to find out who is playing whom. Who decides whether an EQIA will be carried out on any of those proposals?

On the issue of the dramatic reductions in waiting lists and reforms of accident and emergency and delayed discharge, can we have more information about when those reviews will be completed? The representatives from Diabetes UK whom we met last week said that there is duplication between primary and secondary care. There is no framework for diabetes. If we are wasting money because of duplication, we need to know about it.

Finally, the pharmaceutical delivery plan states:

"The achievement of efficiency saving will be monitored on a quarterly basis."

Can you outline the time frame for that? Do you mean that it will be monitored on a quarterly basis from April? Has that been monitored, when will it be monitored, and who monitors it? Thank you, Chairperson, for your indulgence.

The Chairperson:

A couple of those questions can be answered in written responses, but there were some substantive questions.

Dr McCormick:

I will make a couple of points to give some initial response to Sue's questions. Several different things are happening at the same time, which means that there is a bit of uncertainty in the way in which they are being reported. CSR efficiencies are being worked through and reinvested. That means that there is a programme of managing the existing costs and service development, although that is very limited in the current financial year. We are seeking to ensure that the service developments be targeted at the highest priority groups. That tends to match the need to promote equal treatment and well-being across the community. That is the intention.

The other side of the coin is that, in dealing with securing the efficiencies, we make sure that the efficiencies have the least possible impact on those groups that are most needy groups. That is an important process.

Some of the stories that we are hearing at the moment arise from the trusts that we talked about earlier. The Chairman asked about the issues around the management of deficits. That is uncertain. That work, as I tried to explain earlier, was based on assumptions that the trust has been making up to now. Those assumptions will change as a result of the Executive's decision around the fact that we are now in a better position than was allowed for.

We had to ensure that we did not overspend as a Department. Such overspend was ruled out absolutely. Managing that process has been very difficult, and that has given rise to some of the stories that you are hearing. I hope that we can now steer a way through that and find a better outcome. I will not go further until we have a final position that the Minister is happy with, and then we can talk in more detail as soon as possible.

Ms Thompson:

Efficiency monitoring, in which we compare information from each organisation with the target that they have been set, is done quarterly. We confirm where each organisation is against its target.

The trusts have looked at their EQIAs and have put those through as part of their normal processes.

Mr Donaghy:

I will make a brief comment on generic prescribing. This is not to answer your question fully, as I think that it will be necessary to follow that up. The intention is to distinguish between instances in which it is necessary to prescribe a proprietary drug, and the stated intention to increase the level of generic prescribing by general practitioners in Northern Ireland so that the cost of each prescription is lowered. Significant progress has been made on that over the past three or four years. That issue was highlighted by John Appleby, and strides continue to be made. However, we will provide further information on the scale of the targets.

Mr Easton:

I am similar to Iris in that I view this in a simplistic way. Perhaps I am doing something desperately wrong. However, when I was re-elected in 2007, the health budget was approximately £3·5 billion. In 2011, it will be approximately £4 billion. That is an increase of one eighth over four years. I cannot get my head around the fact that that is a huge increase, yet we are having all these problems. Perhaps you can help me with that.

Looking at the audit of management costs for the Health Service, I have found that in some trusts, despite decreases in mangers and their associated costs, there has been a 13% or 25% increase in overall costs. Those are audited accounts that we have in the Assembly. It annoys me that almost 14,000 clinics are cancelled every year. It seems that nothing is being done to tackle that. If you tackle that, you tackle the number of appointments that are lost and the amount of time that is lost to staff owing to appointments being cancelled at the last minute.

Perhaps you can go over some figures with me from the latest monitoring round and from the gap in the trusts. Was I right in hearing that £10 million will go from capital to revenue, and that the Minister, as he gets the first call, will get £20 million from this monitoring round? Therefore, is the Minister getting an extra £30 million?

My final question concerns swine flu. A portion of the health budget will pay for that. Where will that money come from in the Department? What will suffer? Or do you have that money?

Dr McCormick:

There are many points there.

In the Budget settlement, the Executive agreed that, as each year unfolded and the monitoring rounds occurred, the first £20 million that became available would go to DHSSPS. With DFP's knowledge, we committed our spending plans on that basis. We assumed that it would come, because in every year up until now there has always been at least £20 million available from monitoring rounds. Therefore, that seemed to be a reasonable deal.

Mr Easton:

Is that in each year or each quarter?

Dr McCormick:

Each year. This year has been particularly difficult for DFP in the wider context. As a result, the £20 million has not yet been made available.

However, I am glad that the Executive have said that it is a priority to find that money in the remaining part of the year. The Minister volunteered that we would find £10 million of that sum ourselves by delaying capital expenditure, so we transfer the £10 million that you ask about from capital to revenue. That gets the first £10 million into the current budget, which is where many of the problems we face lie. However, we have not yet had anything over and above that. We still hope that there will be relief on that issue as the year unfolds, but that is not guaranteed. We are waiting for that to happen. DFP has promised to make every reasonable effort to find the £20 million for us. It is important, because we depend on that money for the services to which we might make commitments.

I return to the general point. In the most recent spending review, the real-terms growth that the Executive agreed for the DHSSPS budget, for the three years starting 2008-09, was 1·2% per annum. That is real-terms growth, over and above inflation. However, expert analysis of what it would cost to sustain services reported that we need real-terms growth, over and above inflation, of 4·3%.

That is the reason for our dilemma. That is the level of cost of providing services for the elderly, high-cost drugs and everything else at a standard that is acceptable to the public. Those

are enormous numbers, and they lead to some of the biggest budgetary dilemmas faced by Finance Ministers throughout the Western World. That is the way that it is. When Gordon Brown was Chancellor, the only tax increase that he openly set out was the 1% increase in National Insurance, specifically to fund the Health Service. That is the measure of its significance from a public finance point of view.

The problem is that, locally, the Executive, as is its right, have taken a different view of priorities and have not funded health and social care in Northern Ireland to the same level. That is a legitimate political decision, and all that we can do is advise on the implications of it.

That is why I bring you factual information of what that means. We have a very significant level of unmet need for services in our community. We have enormous health inequality issues that are difficult to address. As Derek Wanless and John Appleby pointed out very clearly, health inequality issues can be tackled only if the public is engaged, but it gets harder and harder when the level of resources is restricted. It involves contributions from the activities and leadership of other Departments as well as our own. That is why we are trying to develop some of the good work done in the Investing for Health strategy and through the ministerial group on public health that began in the previous period of devolution. We perceive major difficulties and some major cost dilemmas.

I am sorry that I have not answered all your points.

Mr Easton:

From where will the swine flu money come?

Mr Donaghy:

The £32 million to deal with swine flu has been found in existing DHSSPS resources. I do not have the precise figures with me, but, before we knew about the prospect of swine flu, a small opening budget was in place to prepare for a pandemic flu.

Mr Easton:

Therefore, the money will not come from any other area?

Mr Donaghy:

The small opening budget had to be supplemented by approximately £20 million in order to reach the closing budget of £32 million.

Mr Easton:

From where did that money come?

Mr Donaghy:

We had to review all expenditure areas and take steps to reduce expenditure spending, so there is, to use the jargon, an opportunity cost, which is money that we cannot spend on other things.

Mr Easton:

Was that money initially earmarked for other things?

Mr Donaghy:

Yes. At the start of the year, all our budgets were earmarked for various things, so we had no option but to review those allocations.

The Chairperson:

Contingency planning — putting aside a little pot of money for such an eventuality — seems to no longer be part of accounting.

Dr McCormick:

When managing our resources, we use the flexibility that the Executive have agreed for us, and, as the Minister said, we have a strong track record in delivering two Budgets. That approach works in normal circumstances. However, swine flu is certainly not a normal circumstance, so we had to face up to managing a very challenging situation.

Mrs McGill:

First, was consultation carried out on the so-called contingency proposals, and who was consulted? Secondly, is an urgent care and treatment-type provision, rather than A&E provision, sustainable for 24 hours a day if, for example, there is no X-ray provision at night?

Dr McCormick:

If, after the Minister has considered the proposals, an element of the deficits was to involve a material service change, we would have an obligation to consult, and we would do so. However, in the context of in-year management, that is rarely the case. We will try to ensure that the budget is resolved and that we get to a plan that allows break-even for the whole health and social care system, so there will be no need to involve a significant service change. I cannot be precise about that point, because we do not know exactly what will happen. Nevertheless, the nature of our obligations is to consult.

Mrs McGill:

The Department's efficiency delivery plan does not refer to contingency proposals. It states:

"Each organisation will identify its proposals and submit them for Departmental endorsement. After due scrutiny and public engagement, efficiency proposals will be finalised for each organisation."

Is that the overall efficiency policy, including for contingency planning?

Dr McCormick:

The process applies to the 3% efficiency savings, and it occurred in the course of a number of recent consultations on service changes.

The Chairperson:

Did the same principle apply to the deficiency proposals?

Dr McCormick:

That would be much less likely, because those proposals are a matter for short-term management. For example, if you have to break even in a financial year, undertaking a lengthy consultation process would mean that the change could not happen and we would not break even, so the obligation to break even must be fulfilled.

The Chairperson:

However, some of those proposals, such as the closure of 75 beds in both Belfast City Hospital and the Royal Group of Hospitals Trust, are very controversial.

Dr McCormick:

All that I can do is to ask you to watch this space. As a result of the Executive's decisions this

week, the context for those matters is changing, and the Minister is considering details, so we can give you some assurance that, before we move forward, we will be looking at a slightly better outcome.

The Chairperson:

Even a short consultation period would be useful. For instance, are you suggesting that the proposals to introduce rapid-response vehicles for Whiteabbey Hospital and the Mid-Ulster Hospital, which, although not important in the grand scheme of things, are very important issues for local communities, could be implemented without any consultation?

Dr McCormick:

There is an obligation to consult when there is to be a service change, and that is what we will do. However, a range of things is happening at the same time.

Mr Donaghy:

The changes that the Northern Ireland Ambulance Service proposed have been fully subject to public consultation, as have the changes that have been proposed for the Mid-Ulster Hospital and Whiteabbey Hospital. A well-trawled public consultation that included substantive engagement was carried out into those proposed changes, and the Minister fully consulted the responses before arriving at his decisions. That was part of the process.

The Chairperson:

The Committee received the proposals for the Mid-Ulster Hospital three weeks ago. Therefore, I cannot see how those proposals can have been properly consulted on.

Mr Donaghy:

You were referring to the overall changes at the Mid-Ulster Hospital and Whiteabbey Hospital, and there was significant consultation on those changes. There were further changes made to aspects of surgery, which sat in that overall design and were part of the earlier consultation.

Dr McCormick:

The Department can provide the documentation and detail on that consultation to the Committee, if that would be helpful.

Mrs McGill:

I would prefer if Andrew answered my question, because it refers back to a point that I made earlier. Do you want me to repeat the question?

Dr McCormick:

No, I can proceed.

The letter of March 2008 confirmed that the Minister was content to approve the Western Trust's proposals. Furthermore, it required that the trust sustain that service and ensure that there be a correct balance between A&E units at the acute centres in the Western Trust area and the urgent care and treatment centre.

From what I recall from your earlier quotation of the trust's recent communication, it stated that it was committed to sustaining that service, and that is what it will do. The trust has an obligation to provide a safe and sustainable service and to ensure that that works. However, it must manage the detail of those arrangements.

I cannot comment on the precise detail of your question, but the Department can respond fully to you in writing if that is acceptable.

Mrs McGill:

My question required only a yes or no answer, and it was whether, at the very point of urgent care and treatment at night, it was sufficient to replace an A&E with a centre in which X-rays are not available. That was my question, but if the Department wants to reply to me in writing, that is fine.

The Chairperson:

Thank you very much, ladies and gentlemen. This evidence session was due to finish at 4.00 pm and it is now 4.55 pm. The witnesses have answered the great number of questions that have been thrown at them by Committee members and have indicated that the Department will respond to several members on various aspects of their questions. Furthermore, I suspect that this will not be the last time that the Committee will be discussing this issue.

I urge members to stay on, because the Committee has urgent business to get through in the

form of correspondence. However, I thank the witnesses again for their time.