COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

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Evidence Session on Comprehensive Spending Review Efficiencies with the Northern Health and Social Care Trust

5 November 2009

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Mrs Michelle O'Neill (Deputy Chairperson)
Dr Kieran Deeny
Mr Alex Easton
Mr Sam Gardiner
Mrs Carmel Hanna
Mrs Dolores Kelly
Mr John McCallister
Ms Sue Ramsey
Mrs Iris Robinson

Witnesses:
Mr Martin Dillon)
Ms Briege Donaghy) Northern Health and Social Care Trust
Mr Colm Donaghy)

The Deputy Chairperson (Mrs O'Neill):
We will now receive evidence from the Northern Health and Social Care Trust on the comprehensive spending review efficiencies. I welcome the trust's chief executive, Mr Colm Donaghy, its director of finance, Mr Martin Dillon, and its assistant director of planning and modernisation, Ms Briege Donaghy. Please make a 10-minute presentation. I ask members to put questions afterwards and to refrain from making statements.

Mr Colm Donaghy (Northern Health and Social Care Trust): I thank the Committee for the opportunity to present evidence today. I extend the trust's best wishes to Jim Wells and his family; we hope that things go well for them. We have given members copies of our presentation; I will go through it quickly and take questions and comments afterwards.

The Northern Health and Social Care Trust is a large organisation that operates in a mostly rural area. The trust has 14,000 staff and a turnover of £550 million, and it provides health and social care for 440,000 people, which makes it the largest trust by population in Northern Ireland.

I will touch on the challenges that face the trust, some of which have been in the public domain recently. At present, the trust provides services from four acute hospitals, and it is moving ahead with a reform programme, which was first heralded some years ago under the Developing Better Services initiative.

The trust is, quite rightly, proud of its history of strong performance against Government priorities and ministerial targets. I want to highlight the growing demand for services in an increasingly constrained financial environment and outline some of the challenges that such an environment presents to the trust as it moves into the future.

First, members will be aware that the settlement for health and social care — the uplift, in real terms, of 1·1% — does not keep pace with demand. The reinvestment of the trust's efficiencies is what will allow it to move forward with the developments that it wants to make in the next several years. Over the three years of the comprehensive spending review (CSR), the cash that will have to be released by the Northern Trust over that period, as members will be aware, is in the order of £44 million. That is a challenging agenda, but it is one that the staff and management of the trust are keen to meet.

The trust's strategic direction focuses on sustainable acute hospital services. Therefore, the pattern of hospital services across the trust area must provide the most accessible, high-quality services that are sustainable for the population in the future. The trust's CSR proposals were recently agreed by the Minister of Health, Social Services and Public Safety, and it is keen to make progress in a number of areas. As the Committee knows, the transfer of inpatient surgery

from Whiteabbey Hospital has taken place, and the transfer of inpatient surgery from the Mid-Ulster Hospital will take place tomorrow. That will mean that more people will be treated at Whiteabbey Hospital and the Mid-Ulster Hospital in future, given the increase in day surgery that will be provided on both sites. The new arrangements represent a more appropriate form of care for the local population.

The trust wants to support people to live independently; its mantra is “own front door”. Where possible, the trust wants to help people whose choice it is to live behind their own front door. The trust wants to move into the future by promoting independence and “own-front-door” solutions for people with mental-health difficulties, people with learning disabilities, older people and children.

The trust wants to provide support for families and children. It is important for the delivery of the trust’s services to do that in the optimum way. The trust wants to work in partnership with the people who receive its services, other agencies outside the Northern Health and Social Care Trust, local government colleagues and this Committee, to ensure that it continues to deliver services that meet the needs of the population. The trust has long recognised that health and social care cannot deliver the population’s healthcare needs in their entirety and acknowledges that a partnership approach is crucial.

I will highlight to the Committee the increase in demand for services. Referrals to hospital outpatient departments are up by 7% this year and 19% over the past two years. That means not only more outpatient appointments, but more diagnostic and related procedures for those patients. Attendance at our accident and emergency departments is up by 6% on last year and continues to rise, resulting in more admissions. The overall birth rate has gone up by 11%, and at Antrim Area Hospital by 36%, but that increase takes into account the transfer of maternity services to there from the Mid-Ulster Hospital.

As members will be aware, the vast majority of health and social care funding is spent at the early and late stages of the life cycle. In 2008-09, the number of people over the age of 85 increased by 13·7% in the Northern Trust area compared with 8·4% elsewhere in Northern Ireland. It will be a major challenge to meet the future needs of that population.

We have performed strongly in addressing hospital waiting times and diagnostics. Our allied

health professionals (AHPS) offer access to physiotherapy, speech and language therapies, child and adolescent mental-health services, and complex discharges from hospital. Those are all good news stories, in that we have improved the level of access for our population in the Northern Trust area. Access has improved not only to acute hospital services, but to community services, and we must sustain that performance.

The trust faces some challenges, such as the provision of accident and emergency services. Although our target is for 95% of people to be seen within four hours of presenting at an accident and emergency department, we find it a challenge to meet that target for a number of reasons, such as the pattern and number of A&E services across the Northern Trust area. That means that our resources are spread more thinly. As we begin to centralise our acute services, we will be able to meet that target on a more sustainable basis in future.

As members will be aware, the maximum time that anyone has to wait for a hospital appointment is nine weeks; for an operation the maximum time is 13 weeks. There is an acknowledged gap between capacity and demand in hospital elective services, but, again, the trust has a good story to tell. Towards the end of last year, we met all those targets, and, as we move into the second part of this year, our intention is to ensure that we meet as many of those targets as we can with the funding available.

Given the growth of the older demographic that I outlined to the Committee, our domiciliary care services will require increased investment. Eventually, some of those people might require permanent placements.

I will outline the savings requirements across the main strands. The target under the review of public administration (RPA) is £7·4 million, and we are well on our way to meeting that target through a reduction in managerial and administrative costs in our organisation. Previously, there were three trusts in the area that is now covered by the Northern Trust. There is now one chief executive instead of three, eight directors instead of 24 and one third fewer assistant directors. That demonstrates how we streamlined the managerial and administrative costs in our organisation as we moved forward.

Efficiency and productivity are strong themes in the overall CSR, and we are taking that forward in conjunction with our staff and the people who use our services. Those two groups of

people can tell us most about how we can improve the care that we offer and how we can make it more efficient or effective. We are closely engaged in that process with our staff and the people who use our services to identify additional areas in which we can improve productivity and efficiency.

The final strand is service reform and modernisation: for example, the service reform of acute hospital services. We are also looking at service reform across community and other services to ensure that we deliver a transformed service that will provide improved access to our patients and clients. Such reform will also help us to deliver on efficiencies.

I went into some detail on the trust's RPA requirements in my written submission. RPA savings have been achieved in several ways that include the merger of three trusts to create the Northern Health and Social Care Trust in April 2007; the introduction of targets to reduce management and administration costs by £7·4 million by 1 April 2010; and the reduction of management posts by one quarter, clinical managers by one eighth and front-line administrative staff by one tenth. Those last objectives has now been substantially achieved, and 121 staff members — a high proportion of which were managerial — have left the trust through voluntary early retirement or voluntary redundancy. Other staff members have also left the trust without taking a voluntary early retirement package.

The next part of my presentation to the Committee deals with the trust's productivity and efficiency. The first point to make is that the trust has improved patient flows through its hospitals. Although I said that the trust does not currently meet the Department's 95% target for four-hour waiting times in its A&E departments, the vast majority of patients attending A&E are seen within four hours. Also, the trust has had only two or three breaches of its 12-hour target for admittance in the past few months. That is a big improvement on the situation three or four years ago, when patients might have waited on a trolley for two or more days in the trust's hospitals.

To improve productivity and efficiency, the trust is managing a reduction in the use of overtime, agency workers and locums in a strictly controlled way. The trust employs a system of risk assessment, and it has introduced protocols for the employment of agency staff. Those protocols allow us to control the reduction in agency staff levels while ensuring that we deliver the current level of health and social care. The trust is also examining how it can improve its skill mix among all of its professions to enable it to reduce costs, while continuing to deliver the same

level and quality of services.

In an attempt to make savings in drugs purchasing, the Committee will be aware that the Department is currently examining contracts with pharmaceutical companies at a regional level. That examination will ensure that those contracts deliver a high level of efficiency.

The use of radiology technology and new picture archiving systems will allow all trusts to create further efficiencies when those technologies are introduced in the next year or so.

Finally, on productivity and efficiency, the trust has plans to improve traffic management at its acute hospital. Part of that would involve charging patients and visitors to use hospital car parks, which has caused some concern in the public domain. However, charging combined with better traffic management system would ensure that patients can get close access to the trust's A&Es, entrances and services as quickly and conveniently as possible. Those factors also help to avoid the traffic chaos that occurred at some of the trust's acute hospital sites in the past.

I provided the Committee with detailed information on the trust's various programmes of care in my written presentation. I will provide a brief update on some of those programmes now. One of the CSR proposals for children's services was to provide alternative residential care for the residents of the Princes Gardens children's home in Larne, through salaried foster carers with appropriate support and respite options. The trust continues to maintain that home while developing options for individual children, and the home will remain open until all of those options have been worked through with the children and their families.

In the area of disability services, the trust currently operates the Widening Choice and Opportunities programme for people with learning disabilities in the Broadway Workshop Adult Centre in Newtownabbey. The trust also provides additional host carers to provide alternatives to inpatient respite services. To date, progress includes the continued work with service users and families, and planning for the recruitment of host carers.

As far as services for older people are concerned, the trust proposed to replace two of its statutory residential homes with modern supported living accommodation and care and support services. That would allow people to stay in their own home and remain independent for as long as possible. The two homes that have been earmarked for replacement are Greenisland House

and Rathmoyle. The trust has engaged closely with the residents, their families and carers and local people as part of the process. The programme to replace both homes is under way.

The Committee will also be aware of the trust’s reform programme for its acute hospital services. The trust is in the process of implementing the changes for the Whiteabbey Hospital and the Mid-Ulster Hospital, and the first phase of those changes is currently under way. The second phase will take place when we are a position, at the Antrim Area Hospital, to ensure that the necessary enabling works have been carried out. We must also be sure that the necessary resources have been invested to enable us to cope with the rationalisation of the A&E and inpatient medical services at the Mid-Ulster and Whiteabbey Hospitals. We are making good progress in both areas.

How do we address the shortfall in our CSR modernisation and efficiency plan? In conjunction with our staff, we are taking forward a robust process for identifying how we can deliver further CSR savings. We are confident that, over the next period, we will be able to deliver against that challenge.

From this month until the end of March, our in-year contingency plan will concentrate on vacancy controls, and on goods and services, as areas wherein expenditure may be reduced. The plan includes delaying proposals for service development that we wanted to progress this year, but will be unable to do so because of the financial situation. If we are able to deliver against the contingency plans, they will not have a seriously adverse impact on the quality of services for patients and clients, but it will enable the trust to live within the funding available for this year.

The agenda is extremely challenging, and we are aware of the tightening financial constraints. The trust is determined to deliver an improved level of care health and social care to the population while living within its resources. The challenge is to achieve a balance between patient safety, performance and finance, and we take that challenge seriously.

The Deputy Chairperson:
Thank you. The normal procedure is that the Chairperson asks some questions, after which the member who represents the relevant constituency is allowed to be the next to ask questions. As I am the only member who represents a part of the Northern Trust area, I ask members to allow me some leeway.

We have asked each trust about the duty to break even. Legally, trusts cannot carry forward deficits. What difficulty does that create for you? How would you feel about a change in legislation to allow you to carry forward a percentage of your budget as a deficit? Would that be helpful?

Mr C Donaghy:
I will let Martin deal with the accountancy rules. From our discussions with the Department, we believe that, if we can deliver against our contingency plan, our income and expenditure will break even. However, given the level of deficit between now and the end of this year, the Northern Trust will require some assistance to do that. If we deliver on those contingency plans, and we are determined to do so, we will break even.

Mr Dillon (**Northern Health and Social Care Trust**):
My personal view, formed to some extent by my professional background, is that some year-end flexibility would help. At times, albeit not recently, it became known that the trust was in surplus as it approached year end. We had to spend that money, but we could not always guarantee that we were spending it wisely. Sometimes, we rushed out and bought equipment that had to be kept as stock because we were unable to use it immediately — some of our spending decisions were not the wisest. A little flexibility around year end would be useful.

Some of the existing legislation permits trusts to be within 0·1% of their budgets, and that is defined as break-even in some of the departmental guidance. Other guidance suggests that break-even can be defined as within 0·5% either way. The difficulty with flexibility is that, if the trust runs up a deficit in any one year, of as little as 0·5% of the budget, under current legislation, that must be recovered. Therefore, we would be storing up problems for a new financial year. Finance professionals have debated long and hard with the Department on the subject, but there is no easy answer. For the moment, the Department remains of the view that “break-even” means exactly that — as close to zero as possible. However, that causes difficulties, not only from a technical accounting perspective but because it calls into question the wisdom of some spending decisions.

Mr C Donaghy:
The ability to carry over a deficit into the next year is useful for only one year, because the trust

cannot go above that deficit the following year. Were it to do so, it would get into deeper trouble and would have to break even on its deficit the following year. Therefore, the deficit is flexible for only one year.

The Deputy Chairperson:

You said that the trust will achieve £3·5 million of reduced spend in-year, but that it will mean some slippage in service developments. Which service developments are you talking about?

Mr C Donaghy:

It will probably affect several service developments, and we are working through the detail of that. Recently, we received notification from the Department about the contingency plans for this year. Is the Deputy Chairperson happy for us to provide the Committee with the details?

The Deputy Chairperson:

Yes. You know where I stand on the closure of acute services at the Mid-Ulster Hospital and elsewhere and the closure of the Mid-Ulster Hospital. One of your papers said that some patients from the Mid-Ulster Hospital will be streamed to Craigavon: did I pick that up correctly? Are you talking about patients who live on the border of the Southern and Northern trusts?

Mr C Donaghy:

We are talking about patients who live in the south Cookstown area, which is the more natural catchment area for the Craigavon Area Hospital. Provision has been made for that by the two trusts.

Ms Briege Donaghy (Northern Health and Social Care Trust):

Perhaps the word “streaming” is a wee bit confusing. It is not so much that we will stream and divert people; rather, we looked at the postcodes of the people who attended the Mid-Ulster Hospital for emergency surgery to anticipate which hospital other people in that area would probably use. Given the location, we anticipate that a small number of people are likely to use the Craigavon Area Hospital. We, therefore, liaised with the Craigavon Area Hospital during the process of change.

However, the vast majority of patients will still attend the Mid-Ulster Hospital, where day surgery and outpatient services will still be provided. All planned surgery takes places in

hospitals in the Northern Trust area. However, streamed patients will be those who need emergency treatment and who might travel from their homes to the Craigavon Area Hospital.

Mr C Donaghy:

We do not propose to close the Mid-Ulster Hospital. It will remain a dynamic site for the provision of care, including surgery. Once the changes have been worked through, more people will receive day surgery and day procedures on the Mid-Ulster Hospital site than currently.

The Deputy Chairperson:

That may be your take on it, Colm, but I do not agree. The Mid-Ulster Hospital is being stripped of services, and people who live in areas such as Pomeroy are being neglected and left in a black hole. My feelings about that are on record.

I am delighted that Cherry Lodge has been reprieved, but is there a move towards having salaried foster carers? Is that still being taken forward as a pilot to see how it works?

Ms B Donaghy:

As you implied, we proposed, in the first instance, to make changes at Cherry Lodge, which has two inpatient respite beds. However, on the basis of a significant consultation exercise that we carried out, we do not propose to move forward with that change at this time. We still strongly recommend that the trust work with families to move towards the provision of salaried foster care, because that would make the availability of respite much more flexible.

However, we appreciate that is takes some time to work with people and build up their confidence. That is why we said that we will not be able to make that change during the current CSR period. However, we will pursue that aim strategically by working closely with individual families and identifying appropriate matches between carers and families. It is important to build up that confidence. We still want to pursue that aim, but not immediately.

The Deputy Chairperson:

I agree that, for people to be confident that the service provided for their child will be suitable, they need to see how it works in practice.

Dr Deeny:

Thank you for your presentation; you have answered most of my questions already. Mr Donaghy talked about an improved level of care, which we like to hear. He also mentioned efficiency savings, which present a heck of a challenge. I have an interest as a GP in an area west of the area covered by the Northern Health and Social Care Trust.

The Northern Trust is the third trust to close an acute hospital in central Ulster. Each one of those closures compounds the situation. The Southern Trust was the first trust to remove acute services from a hospital, with the closure of acute services at the South Tyrone Hospital in Dungannon. That was followed by the removal of acute services from a hospital in the Western Trust. I agree with the Deputy Chairperson that people are worried about the loss of life-saving services. Colm, you talked about the services that are provided in hospitals, but a hospital is not a full hospital unless lives can be saved there, and the bottom line is that blue-light ambulances will not be able to stop at the Mid-Ulster Hospital.

The Northern Trust is the third hospital to remove acute services from a hospital. We need to work together and engage in joined-up thinking about a large population in the centre of Northern Ireland that is being left bereft of life-saving services. You talked about Pomeroy; I know it well. It is the highest village in Northern Ireland, and, in two months' time, it will be difficult to travel its roads. The people there will feel left out, as I have said for a long time. I presume that the Northern Trust has the same periphery and boundaries as the former Northern Health and Social Services Board.

Mr C Donaghy:

That is correct.

Dr Deeny:

It may seem laughable, but I remember some years ago mentioning to a patient the need for a referral to Holywell for mental-health services. The patient had never heard of Holywell and thought that it sounded like somewhere in Los Angeles. People in my area feel that they are away from the centre of the Northern Trust. Are you not loyal to those patients? Will you not see to them? Can you not pipe up and tell the Department to hold on? Rather than follow its orders to close services, will you not say that there is something wrong, because that would be the third life-saving hospital in the centre of Northern Ireland to close? What are you going to do for

the patients in the centre of Ulster in places such as Cookstown, Pomeroy and Kildress who feel that they have lost their hospital, as do the people in Dungannon, Omagh and west Tyrone?

Mr C Donaghy:

I will try to deal with all of Dr Deeny's questions. As the Committee knows, the drive to improve hospital care has many facets with regard to trends in provision, training requirements, Royal College requirements and patient-safety requirements. Given that we are doing more with the technology that we have in day surgery and day cases, which is good, there are fewer requirements for hospital beds. That leads us to the position in which we find ourselves. All the changes in medicine, surgery and trends in technology make it increasingly difficult to sustain inpatient services, which are what we are talking about, on a vast range of sites. As you know, it becomes more difficult to attract nursing and medical staff to sustain those services.

I am responsible for managing those services, and, if it gets to a point at which clinicians, the Royal College and others advise us that the services may or will become unsafe, we need to take action that will continue to provide safe services. That is the irony: we are not taking away a life-saving service; we are putting in place more appropriate life-saving services for the population in Northern Ireland, and doing so leads us to consider what is the more appropriate model and pattern of provision. In the Mid-Ulster Hospital and Whiteabbey Hospital, that means ensuring that we continue to provide access to the most appropriate care for patients and clients in those areas.

Approximately 70% of the people who currently attend the Mid-Ulster Hospital A&E, for instance, will still be able to attend the urgent care and treatment centre there, and more people will be treated through day surgery and day case work at the Mid-Ulster Hospital than is the case at present. However, the current level of inpatient acute care at the Mid-Ulster Hospital will no longer be available. However, the model that we are putting in place is safer and more appropriate for the quality of care that we want to deliver to patients.

Dr Deeny:

Leaving aside buildings, do you believe, as we do, that the whole of Northern Ireland has become unsafe? Someone could have used a bit of forward thinking and suggested that three hospitals be replaced with one good one in the centre of Northern Ireland — that would have attracted staff. The whole area, Colm, is becoming unsafe. The bottom line is that, in the middle of winter,

people cannot get to a hospital in time for their lives to be saved. I have worked in the community for 27 years, and the area, never mind the buildings, has become unsafe. Do you accept that?

Mr C Donaghy:
I do not accept that the area is becoming unsafe or that the level of care is unsafe. I argue the opposite side of the coin: we are attempting to ensure that we deliver quality care that is safer than it is currently.

You made an observation that one large hospital could have been built. We all know how long that might take and what the planning considerations and costs might be. The new hospital that is being commissioned in Enniskillen will cost around £400 million. If the trust were to consider building a new hospital in the future, that would be a much longer-term objective.

Ms B Donaghy:
When the proposals were out to public consultation, we were anxious to hear the concerns of people in mid Ulster, and I have great empathy with the concerns that were expressed. Colm talked about people working together to find solutions. At last month's meeting of the trust's board, we presented our business case for the expansion of Antrim Area Hospital's A&E department. That business case specifically set out a unique proposal for the provision of urgent care and treatment services at the Mid-Ulster Hospital. We worked closely with medical staff at the Antrim Area Hospital and the Causeway Hospital, and we also worked with local primary care providers and GP out-of-hours services. We propose to run a unique model of service at the Mid-Ulster Hospital that is medical-led and moves beyond what people term as minor injuries services.

It is early days, and we still have to discuss the model in more detail and consider its sustainability, but it represents a direct response to the concerns that were raised with us by local people during the consultation. We are keen to work with primary care colleagues, commissioners and others to work up that model into a sustainable model of service and, perhaps, bring added value to it.

Mrs D Kelly:
Thank you for your presentation. The proof of the pudding will be whether your plans satisfy the

people whom you serve. I wait with interest to see what happens, but, thus far, you seem to have made a good effort.

I am interested in the trust's rise in admissions to accident and emergency. I wonder what analysis was conducted to find out how many of those admissions were genuine A&E admissions or whether they were the result of a lack of GP out-of-hours services or an increase in the number of people who cannot be seen at outpatient clinics.

I know from experience that the closure of beds in long-stay residential care for mental-health and dementia services causes great upset for relatives. Anecdotal evidence suggests that people who move out of residential care seem to die quickly thereafter. Some people have related that experience to me: how will you handle that?

You referred to introducing salaried foster care and finding savings in children's services, but surely you cannot do both. To build confidence, you must introduce salaried foster care to demonstrate that the service has improved. How will you address that?

Have you recruited a forensic psychiatrist in your trust area? Given that you provide a local service for people with personality disorder, does the Northern Trust use the Knockbracken units, or do you envisage using a similar type of unit?

Mr C Donaghy:
If you do not mind, I will answer your last question first.

Mrs D Kelly:
Why not?

Mr C Donaghy:
As you know, the Department invested in forensic psychiatry two or three years ago. The trusts work with the service at Knockbracken to deliver community forensic services in their respective areas. The Northern Trust employs a consultant in forensic psychiatry, and we work closely with Knockbracken in the delivery of our services. We have forensic mental-health beds in the Northern Trust area, and we do not intend to extend that provision. However, it is a well-made point that we must work more closely to ensure that much of the need for forensic psychiatry in

Northern Ireland is dealt with appropriately.

You are correct that the proof of the pudding will be when we have introduced salaried foster carers and can show that they represent a better way forward. In principle, salaried foster carers are a better way forward, because they stabilise foster caring and help us to address our dearth of foster carers. We spend quite a bit of money on private foster care, because we have trouble attracting foster carers. Salaried foster care will enable us to reduce the money that we spend on foster care in the private sector, so it will pay for itself.

Ms B Donaghy:
In the northern part of the trust area, we have a similar scheme that is largely meant for young people and adults with learning disabilities. That scheme is known as Share the Care and has worked successfully for some years. Some members may be familiar with the scheme, as part of which we recruited people to provide flexible respite. We have examples of good practice, but they are not well known to people in other areas, because we have not extended the scheme. Therefore, we must build confidence. The scheme was a direct response to the lack of residential availability for care and has been a success. We will share such examples with families to demonstrate the flexibility that we can offer and the types of carers that we can attract.

Mr C Donaghy:
Dolores, you also asked about the resettlement of people with dementia. Our emphasis is on the provision of care for people who may not yet be in residential facilities. The resettlement of people who live in those facilities will be done in a manner that is sensitive to their needs and to the needs of their carers and families. We will not carry out the resettlement in a manner that would result in a high death rate.

I do not have the detail of the A&E analysis in front of me. Many people who turn up at A&E could, probably, be better dealt with by their GP or out-of-hours GP. All sorts of reasons could be proffered as to why people turn up at A&E, but we will work closely with the new Health and Social Care Board on a demand analysis to try to reduce the number of people who attend A&E when they could attend a more appropriate venue.

Ms B Donaghy:
I am familiar with the figures, so I can detail some of them. As Dolores Kelly said, there has

been a 6% increase in attendance at the A&E services at all four hospitals in the trust area. After analysing that figure, we found that, rather than it being due to an increase in self-presenters, it was due to an increase in arrivals by ambulance and in the number of patients being directed to A&E by GPs. The increase in patients being directed to A&E by GPs was not due to a lack of provision of GP out-of hours services, because the former service delivery unit audited whether those arrivals were appropriate and whether they were appropriately admitted. The assessment found that the Northern Trust had one of the higher rates of appropriate admission. Although a higher number of people are arriving at A&E, those arrivals are, largely, appropriate. Colm mentioned recent work with colleagues in primary care. In the first part of this year, we saw a modest downturn in the numbers attending A&E via GP services, although there is still an overall increase. However, as the audits determined, the admissions have been, largely, appropriate.

Mrs D Kelly:

We all hear stories of weekend admissions to A&E, many of which are related to alcohol, and those, surely, are bound to skew the figures.

Ms B Donaghy:

Absolutely, that is always the case. However, in the overall scheme of things, the arrivals are, largely, appropriate. Notwithstanding that, there are particular issues at A&E.

Mrs D Kelly:

I could not help but gasp when Colm said that the Mid-Ulster Hospital was safe from closure. A former colleague of his once said that, following the bomb at the Brownlow Health Centre, Moylinn House would never close, but it closed within three or four years.

Ms S Ramsey:

Notwithstanding the problems that members raised, the Northern Trust's realisation that efficiency savings must be made comes as a breath of fresh air. Martin said that surplus money was not always spent wisely; that seems to be a theme of how public sector money is spent. The Northern Trust accepts that it must make efficiency savings and is demonstrating how that will be done.

However, the trust's presentation also raised many questions. Some of those questions relate to reducing expenditure on travel, training and home maintenance, which makes me wonder how

much public money has been spent on those issues throughout the Health Service.

The Northern Health and Social Care Trust has been told to produce efficiency savings of £44 million and, parallel to that, £50 million will be released back for improvement and service provision, which makes sense. In my view, money that has been wasted is being reinvested in front-line care — those are my words.

Colm referred to the delay in creating pharmaceutical contracts. What is the reason for that delay? All Departments are experiencing problems with their budgets. I appreciate that you may not have the answers today, but we would appreciate an update on what is happening with the supported living project in which the Department for Social Development (DSD) is involved.

I appreciate what you said about discussions on proposed changes with staff and users where possible. It is important to keep people up to date and take them with you on that journey of change. I also appreciate your comments about the controlled reduction of agency staff. You will have heard the Committee's discussion earlier about service providers.

Have you any idea how much money car parking charges will free up? The Committee has a difficulty with people being charged to park at hospitals. Is PFI involved in any of the trust's car parks? We have seen the debacle that resulted from the involvement of PFI when other hospitals charged for parking.

You intend to reduce expenditure on travel. What about the taxi contracts, and why were they used in the first place? That question is not intended as a criticism against anyone at the table.

On 27 October, a statement from the Minister confirmed:

> "that some £20 million is now being released to trusts to sustain work to achieve waiting time targets."

That is fair enough, and I support that. The statement went on to say:

> "This will include the resumption of independent sector activity where this is critical to maintaining reduced waiting times."

Colm, you mentioned streamlining and talking more to the community and voluntary sector about providing services. Is that connected to the independent private sector and people going to England for operations?

Mr C Donaghy:
No.

Ms S Ramsey:
OK. That is fair enough.

I asked the next question of the Belfast Trust as well: what was the level of legacy debt before, in your case, the three trusts became one? Was any chief executive held to account for those debts? Had the trusts been private companies, they would have been held to account.

I will end with a phrase for which I told Dolores I would give her credit: it is a matter of doing things "smarter, not harder". I appreciate that you are taking staff and service users on that journey with you.

Mr C Donaghy:
I will attempt to deal with as many of those issues as possible, Sue. If there are any that we need to update you on at a later stage, we will, as you suggested, do so.

The delay in making some savings from pharmaceutical contracts is linked to the negotiations at a regional level.

The Deputy Chairperson:
In your proposals, you state that you expect to make savings of £3 million from regional procurement of pharmaceuticals. Obviously, that will not happen. How will that impact on you?

Mr C Donaghy:
Before Martin provides that detail, I want to say that, in managing our deficit in 2009 and looking to the future, we have taken that into account. Some CSR proposals that we identified will not deliver savings according to profile. If, for example, pharmacy contracts do not deliver some of the anticipated savings at regional level, we will have to put in place contingency measures to make up for that gap in-year to enable the organisation to balance income with expenditure. However, should that happen, we have plans in place to deal with it.

Mr Dillon:

My understanding is that pharmaceutical savings during the CSR period were estimated at around £40 million. The vast bulk of that money would fall outside acute hospitals; some £32 million would fall to primary care. The acute hospitals were expected to reduce their costs by around £8 million on the back of new contracts and improvements in their use of pharmaceutical products. My most recent information is that the acute hospitals are on track to achieve that £8 million.

However, as is the case for all trusts, we find that, even if we can get some costs down in pharmacy, those are offset by new pressures, such as new patients coming on to treatments and new drugs becoming available. As well as that, pharmaceutical companies often introduce big price rises. Therefore, although savings come out in accordance with what was agreed in one area, they are offset in a goodly measure by new pressures that arise elsewhere. That is part of the difficulty that trusts face at present: although we can make savings on one hand, suddenly, a raft of new pressures on the other hand negates those savings.

Mr C Donaghy:

We will provide the Committee with a more detailed written update on supported living and DSD funding. Briefly, we are working closely on a local supported housing project to ensure that we identify DSD funding that will assist us in taking forward the plans for two residential homes. As you know, Sue, in the current economic climate, there are no guarantees. However, we are working closely with colleagues in the Housing Executive to identify and secure funding from the Supporting People scheme.

Ms B Donaghy:

We continue to pursue that with DSD, although it stated that it may not have the required capital or, indeed, revenue. However, as Colm said, we continue to pursue that, because people in our locality are as needy and deserving of that kind of investment as those in other areas.

In parallel with that, we are working with two stakeholder groups; one in Greenisland and one in Ballycastle. We have been open and transparent about the fact that we may have to test the market for available independent providers, particularly, as Colm mentioned, housing associations that can bring capital and revenue to the table. We have had initial indications from some of them, such as the Fold Housing Association and BIH Housing Association, which is now called Helm Housing.

We are confident that, if we are not able to secure DSD funding in those cases, independent providers may well provide an opportunity. It is a challenging and difficult situation that requires us to be innovative. However, we are confident that we can meet the challenge, particularly if we work closely with stakeholders and residents.

Ms S Ramsey:
It is a matter of thinking outside the box.

The Deputy Chairperson:
It could prove more expensive to approach independent providers than DSD. I understand that there are many good providers of supported living in the voluntary and community sector.

Mr C Donaghy:
The establishment of a supported living scheme requires bricks and mortar. The independent sector might able to provide the capital of which there is a dearth in the public sector. There are several advantages to a process whereby an independent sector provider builds and sells the houses. Some older people, for example, have equity in their current home, and, when they move into statutory provision, a financial assessment takes that equity into account. If they were to buy into new developments in supported housing, they would receive a menu that outlines the level of service provision that is available, and they could bring their equity with them to their new home.

Several trusts had made advances on that issue prior to the current downturn. Given the position of the global economy, it is much more difficult to make progress. We are still pursuing that as an option for future provision. However, if an independent sector provider were to come in, it could provide the capital to build a supported housing scheme in which we could provide the care. That would get round the issue of finding the capital to build.

The Deputy Chairperson:
Have you answered all the questions?

Mr C Donaghy:
There was a question about car parking. I want to emphasise that ours is a traffic management scheme, the primary purpose of which is not to generate income. It would generate a small

amount of money. Its primary purpose is to ensure that patients and visitors enjoy closer access to our hospital. That traffic management scheme will allow traffic that is closer to the hospital to be managed in a way that enables people to gain access. For example, approximately 80% of people who visit our hospitals stay for less than two hours, whether for an outpatient appointment or to visit a relative. The charging regime that will be introduced will be £1 for up to two hours. The emphasis is not on generating money; it is on ensuring that people who need close access to the hospital receive that in a timely way.

Ms B Donaghy:
The scheme will be run by the trust; it will not be a PFI scheme. Any money that is generated will return to the trust.

Mr Easton:
Colm, your job will be harder in this trust than in the previous one. You will reduce your dependence on agency staff. Is that right?

Mr C Donaghy:
Yes.

Mr Easton:
I noticed that there will be a reduction of 41 nursing posts. Will those redundancies be compulsory?

Mr C Donaghy:
No; they will not be compulsory.

Mr Easton:
Would it not be cheaper to maintain those 41 nursing posts? I know that you will still use agency staff and that there must be a happy balance between nursing staff, agency staff and bank staff. However, agency staff cost two or three times more. Would it not be cheaper to maintain those 41 nursing posts than to use more agency staff? I accept that you will reduce the number of agency staff that you use anyway. Given that nurses are front-line staff and are cheaper to use, it makes more sense to use them than to use agency staff.

I assume that the Minister has agreed to your efficiency proposals?

Mr C Donaghy:

Yes.

Mr Easton:

How do those proposals differ from the first set?

Mr C Donaghy:

Which efficiency proposals?

Mr Easton:

I mean the initial proposals that were presented to the Committee before you became the chief executive. Are they slightly different from the ones that the Minister has agreed? Have there been more proposals since then?

Mr C Donaghy:

The only difference between the proposals that the Committee was aware of and the subsequent CSR proposals is that the Minister did not agree that we should increase the number of private sector providers of home care services. Currently, 80% of home care in the Northern Trust is provided by the statutory sector. We had proposed to skew that figure deliberately so that the statutory sector would provide 60% of care and the private sector would provide 40%. The Minister did not agree with that proposal, and that is the only change that has been made.

Mr Easton:

Sue Ramsey asked you about taxis. Do you have a taxi contract?

Ms S Ramsey:

They tried to avoid that question.

Ms B Donaghy:

We use taxis, and we will continue to use them. However, in order to secure better value for money, we need to be smarter about how we arrange contracts. Taxis are used, for example, to bring young people and adults to day-care services, so there is a need for flexibility and

individual responses. We need taxis, but we could be smarter about how we use them.

With respect to the reduction in nursing staff, we calculated a minus figure of approximately 41. However, it is important to emphasise that, as Colm said, those proposals are based on averages. We employ 5,000 nurses, and, overall, we do not envisage a reduction in nursing provision. If averages are calculated for each scheme, an overall figure of minus 41 is arrived at. In the grand scheme of things, we employ 5,000 nurses, and we do not expect to see an overall reduction in the number of nursing staff. It is important to remember that some of those calculations are based on average figures, so we cannot predict definitely that there will be precisely 41 fewer nurses. That is not to say that there will not be a small reduction in numbers, but such predictions cannot be absolutely precise.

Mr Gardiner:

Colm, it is lovely to see you again. Congratulations on your temporary transfer, which, although it is the Southern Trust's loss, is certainly the Northern Trust's gain. I wish you well. How long will you be in your temporary position?

Mr C Donaghy:

One year.

Ms S Ramsey:

Then he will move on to sort out the rest of the efficiency savings.

Mr Gardiner:

I was going to ask you about efficiency savings. Can your trust bear many more cuts before it goes into the danger zone in which lives will be put at risk and the required standard of care will no longer exist? I am concerned about that.

Mr C Donaghy:

The current environment is extremely challenging. Given the level of complexity of, and the demand for, our services and the resource constraints that we must deal with, things are finely balanced for us, and that is extremely challenging.

Mr Gardiner:

Are you just about coping and no more?

Mr C Donaghy:

Yes.

Mr Gardiner:

I hope that the day when you cannot cope never comes.

Mrs Hanna:

Colm, you talked about the new configuration of services, streamlining and reduced administration. Is there any evidence that the service will work better as a result? Furthermore, even if there are no savings yet, can you at least see trends that anticipate savings? You spoke about the duty to break even and about the fact that you might need assistance to do so. Will you elaborate on that a little?

You mentioned the fact that the number of outpatients has greatly increased, but you also said that the number of patients who require acute beds has increased. Are there simply more sick people, or is there a quicker turnover of beds because primary care services are better?

Dolores Kelly spoke about A&E services. Have you done anything about the patients who come to A&E with alcohol-related illnesses, perhaps by involving public health experts?

Finally, we all know about "targetitis", so, although we accept that targets must be achieved, what have you done to achieve the balance between meeting targets and providing a half-satisfactory service? We often hear that efforts to meet targets result in falling service standards.

Mr C Donaghy:

Thank you, Carmel —

Mrs Hanna:

If you have time, I have one more question. You talked about managing traffic. Have you considered providing free car parking for long-term patients and their relatives?

Mr C Donaghy:

I will answer the last question first: as part of the traffic management scheme, which involves charging for parking, there is an exemption policy for long-term, cancer and other categories of patients. Not all parking places are charged for. People would have a choice, but those who park closest to the hospital are the ones that we would charge.

On the issue of whether the service is working better, the final phase of the review of public administration finished as recently as April. Therefore, the regional organisations — the Health and Social Care Board, the Public Health Agency, the Patient and Client Council and the Business Services Organisation — all came into being back in April. From a trust perspective, the reorganisation has improved the way in which we work to deliver care in the future.

Our organisations at the top level are now based around the programmes of care that we have introduced, which had not previously been the case. Therefore, we are no longer based around an institution, nor are we providing care down very strictly professional lines — medical, nursing, AHPs or social working. We have introduced programmes of care. We have children and young people's directorates in our organisations, which provide care, and for which we plan across health, social care, nursing care, AHPs. That is not to say that professionals are not important: they remain extremely important in that mix, as are the institutions. However, our focus is more on the patient and client pathway across programmes of care than it was before. The 18 organisations that previously existed had different management systems that were not organised across a patient flow or programme of care process.

Some people might perceive that more managers have been introduced. In the past, an AHP reported directly to the director of AHP services. Now, he or she probably reports to an assistant director, because of the scope of responsibility that that assistant director now has across the trust and the programme of care, as opposed to down a narrow professional line. The appearance of more tiers creates the perception that there are more managers, but I assure the Committee that there are not.

The first thing to say about how the service works better is that the programme-of-care approach — and I again use children's care as an example — puts us in a better position not only to deliver care in our organisation and plan holistically for children, but to integrate and interface with agencies outside our organisation in a much better way. Therefore, as we move into the

future, we are able to integrate better with those in education and others because our focus is on care for children. We are only two and a half years into the period covered by the CSR, and we will make more progress in that area. It will be seen that we take much better advantage and opportunity of the fact that we are an integrated health and social care system.

Northern Ireland has a fantastic opportunity. In England and elsewhere, primary care trusts (PCTs); mental-health trusts; learning disability trusts and social services are within local authorities. The system is totally fragmented, and Northern Ireland is looked at with envy. We must take much more advantage of that than we did before, and I believe that we are doing so in the current system.

I will explain what I meant by break-even and assistance. The Northern Health and Social Care Trust forecasts a deficit £28·5 million for the end of this year. The Department and the Regional Health and Social Care Board recognise that is an impossibly massive task for our organisation to balance income with expenditure by finding £28·5 million between now and the end of the year. Therefore, we agreed to contribute to a balanced position. Our contingency plan will contribute £3·5 million between now and the end of this year. We must also deliver on the CSR and some of our other outstanding recovery plan processes to the tune of a further £3·5 million, which means that the trust must contribute a total of £7 million this year. The Department said that, if we are able to meet that target, it will set what is called a controlled total for the trust. That means that, if we meet those contingency requirements, the Department will provide a controlled total as easement for the Northern Trust this year.

Mrs Hanna

I asked a question about alcohol-related admissions.

Mr C Donaghy:

I have still to answer a few of your questions, Carmel. The growth of outpatients and day cases demonstrates that we are providing care in a much more accessible way. It also means that we have a quicker turnover of patients, and, therefore, we do not require as many inpatient beds as previously. The lengths of stay are shorter, fewer people need to stay in hospital, and we are delivering care on a day case and outpatient basis, all of which means that must examine the pattern of care as we move forward.

Many analyses have been carried out on accident and emergency and alcohol-related incidents; Briege might be aware of some of the local ones. A psychiatric liaison service is in place at the Antrim Area Hospital, the Causeway Hospital, the Mid-Ulster Hospital and other acute hospitals. That service ensures that people who attend hospital at night because of alcohol-related problems are given a psychiatric consultation quickly thereafter.

There is much debate about whether targets are good or bad. At this point, they are good for the Health Service in Northern Ireland, given the length of time that some people have had to wait for elective care. Health and social care now has a good story to tell about the reductions in the length of time that people have to wait for hospital treatment.

In some cases, targets can be counterproductive, but a listening ear is now more readily available to us should that be the case. The Department is prepared to be flexible on how we ensure that the delivery of targets does not continue to be counterproductive.

Mrs Hanna:

In relation to the pharmaceutical contracts that you mentioned, what percentage of your drugs is generic?

Mr C Donaghy:

That is a good question.

Mrs Hanna:

That is an area of proposed savings.

The Deputy Chairperson:

Perhaps you will come back to us on that.

Mr C Donaghy:

Yes, we will.

Mrs I Robinson:

Colm, it is nice to see you and your colleagues. Correct me if picked you up wrongly, but I understood you to say to Carmel that the controlled fund means that, if the trust can find £7

million, the Minister will write off the rest of its deficit.

Mr C Donaghy:

No. There is a well-documented process for trusts that have financial difficulties in any jurisdiction, including England. The Northern Trust is in the process of turning round its financial position and putting in place plans that will eventually see the trust break even on income and expenditure. During that process, non-recurring funding is required to bridge the funding gap in the Northern Trust to ensure that it is able to balance income with expenditure over a period. The controlled total that I mentioned is a contribution to the Northern Trust in relation to its deficit. The money is not written off as such; it is transferred to the accounts of Northern Trust to allow it to balance income with expenditure.

Mrs I Robinson:

Nevertheless, it is money coming into the trust. That £20 million will be written into the trust's accounts to allow it to balance its books. Obviously the Minister must have that money in a slush fund or something, because he pleads poverty. Where is that money coming from?

I also want to raise some points about elective surgery. Do the surgeons and theatre nurses move from the hospitals currently providing surgery to the two hospitals to which surgery is being transferred? Do the professionals follow the surgery?

Mr C Donaghy:

It is a mixture. Some professionals follow, but, as I said, day surgery and day case work will continue at Whiteabbey Hospital and the Mid-Ulster Hospital. Therefore, some surgeons and staff will remain at those hospitals to provide that level of care.

At the Mid-Ulster Hospital, for example, two surgeons will continue to provide full lists of elective surgery from Monday to Friday. At Whiteabbey Hospital, the surgeons will continue to provide day surgery. Nursing and other support staff will still be required at those sites to provide that level of care. That said, some staff will also transfer to Antrim Area Hospital because of the increasing amount of surgery required there.

Mrs I Robinson:

What, if any, surgery is farmed out to the private sector?

Mr C Donaghy:

In the second half of this year, we have reduced the amount of expenditure in the independent sector. However, if we continue our current level of spending over the course of the year, we forecast that we will spend up to £6·5 million for work in the independent sector. Iris, that is, primarily, funding that has already gone to the independent sector during the earlier part of this year, as opposed to —

Mrs I Robinson:

Are you cutting back on that spending?

Mr C Donaghy:

Yes.

Mrs I Robinson:

Why can that work not be done in-house through the NHS?

Mr C Donaghy:

There are a couple of reasons. We work closely with our clinicians through the job-planning process to maximise our internal capacity. However, the work that we have done with the Health and Social Care Board over the past number of years demonstrates that there is a gap between the capacity of the system and the demand for treatment.

We are in discussion with the Health and Social Care Board to determine how we can sustain the improvements that we have made in access times and treatment for our population. A process of elective care reform will ensure that we maximise our internal capacity and are able to develop the areas in which we need additional assistance, as opposed to having to provide that care in the independent sector. We want to maximise what we can do in-house.

Mrs I Robinson:

I take it that it is more to do with targets being reached and the fact that you do not have sufficient surgeons to do the work on the ground. On the heels of that, how efficient are your theatres? Are they working to capacity?

Mr C Donaghy:

Our theatres are working to capacity, but there is always room for improvement. We are introducing a new theatre management system that will help us to introduce more efficiency and achieve a better capacity from our theatres in the future. As we move forward, one issue is not having enough surgeons and nurses in the system to deliver the current capacity. As you know, that is why we use the independent sector: to ensure that people get quicker access to care. In that sense, the targets were a means to an end.

In the longer term, we want to sustain the improvements that we have made by maximising our current capacity and investing in the areas in which we have difficulties. The targets were a means of making those improvements so that people would get better and quicker access to treatment.

Mrs I Robinson:

Have you considered the option of private professionals coming in to use NHS theatres at night so that they are operational 24 hours a day? Perhaps you do not have the figures with you, but I would like to see how the cost of referring patients to the private sector for hip replacements, and so forth, compares with Health Service treatment.

There is an issue with using taxis: how many volunteer taxis do you use?

Mr C Donaghy:

I do not have that figure to hand, but I will get it for you, Iris. We use quite a number of volunteer taxis.

Mrs I Robinson:

On a personal note — and I would never have dreamt of raising the incident had I not seen it for myself — my mother is 89 and requires a wheelchair because she cannot walk. A frail elderly gentleman was, bless his socks, trying to do something good for the community. That poor wee man came to her sheltered dwelling to take her to hospital for blood transfusions. It took my mother over half an hour to try to walk to the car because there was no wheelchair. I am speaking up, not only for my mother, but for all those frail and elderly people who require wheelchairs and a proper ambulance. I have made a complaint but I want to flag that up. I tell my mother not to answer the door to people whom she does not know, and, therefore, for a stranger to come to her

home flies in the face of all that is acceptable.

Ms B Donaghy:

I will go back to the question about the independent sector. At times, we enable the independent sector or private providers to use the trust's facilities. However, that is largely for day surgery and outpatient services, which, for the convenience of patients, take place during the day and, at times, on Saturdays. The use of the independent sector should be kept in perspective. For example, last year, only 4% of all surgery, and approximately 9% of all outpatient activity, was carried out by private providers; 96% was carried out by NHS surgeons. However, I appreciate that 4% is still significant, and I will get you more detailed figures on that.

Mrs I Robinson:

If you were to allow private providers to use NHS theatres, that would reduce the cost, because they could not charge for their theatre time. That seems the logical way to go. People would not mind going in to hospital at odd hours for surgery; they want that surgery so desperately that they would be happy to come in late at night.

The Deputy Chairperson:

Will you tell me — and we have asked this question of all the trusts — what percentage of the Northern Trust's turnover is spent on administration?

Mr C Donaghy:

The percentage spent on administration is 3·7%, which is less than 4p in the pound. The turnover in the trust varies across professions; however, on average, the turnover is around 7·5%. I will confirm that and get more accurate figures to the Committee.

The Deputy Chairperson:

Thank you for coming today; I am sure that we will talk again in the future.