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Assembly

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

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

5 November 2009

NORTHERN IRELAND ASSEMBLY

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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 Neil Guckian	)	
Ms Charlotte McArdle	)	South Eastern Health and Social Care Trust
Mr Hugh McCaughey	)	
Mr John Simpson	)	

The Deputy Chairperson (Mrs O'Neill):

The next item is an evidence session on efficiency savings with the South Eastern Health and Social Care Trust. Members have been given a briefing paper from the Committee Clerk and a briefing paper and correspondence from the South Eastern Trust. I welcome Mr Hugh McCaughey, the chief executive of the trust; Mr Neil Guckian, the director of finance and estates;

Mr John Simpson, the director of planning, information and performance management; and Ms Charlotte McArdle, the director of primary care, elderly and the executive director of nursing. You are all very welcome. I invite you to make a presentation of about 10 minutes' duration, after which members may wish to ask questions.

Mr Hugh McCaughey (South Eastern Health and Social Care Trust):

I do not intend to cover the entire content of our PowerPoint presentation, because that would take longer than 10 minutes. Instead, I will distil the information into a summary by speaking about four or five key themes. After I have done that, I will invite Neil to talk about the efficiency savings, contingency plan and the trust's financial position in the current financial year.

The South Eastern Trust met the vast bulk of its targets last year. We broke even and balanced our budget, and we have agreed plans to do the same in the current financial year despite a difficult comprehensive spending review (CSR) period. We have to save £12·5 million in the current financial year against a significant increase in demand across most of our programmes of care. Demographic factors are among the key drivers of that increase in demand; I will speak about that in more detail later.

The catchment population living within the trust's boundary amounts to just under 350,000. However, we actually serve a population of some 450,000 because we take in much of east Belfast and Castlereagh, particularly the area around the Ulster Hospital. That fact may explain some of the distortion between the catchment population, as it is regarded, and income through service and budget agreements. I will not speak in detail about our performance last year, but we met our targets across elective care, emergency care, mental health, learning disability, children's services, community services, and so on.

The proportion of the trust's population who are over 65 years of age will increase from 15·23% to 19·15% between now and 2019, and the proportion of the population who are over 85 years of age will increase from 1·9% to 2·59% in the same period. The South Eastern Trust has the second-highest proportion of older people but the fastest-growing proportion of older people. In 10 years' time, the South Eastern Trust will have 15,000 more older people, which is an increase equivalent to the population of Armagh city.

Such increases in the number of older people are being experienced regionally, which was a significant driver in the suggestion in the Appleby report that there should be a 3% to 4% increase in investment in real terms. Regionally, we expect there to be around 60,000 more older people in the next 10 years; therefore, there will be 6,000 more older people every year. There is much documentary evidence that the older population places greater demands on health and social care.

Each year, an additional population of people who are over 65 years of age that is equivalent to a town the size of Ballynahinch is, effectively, dropped into Northern Ireland. That growth in demand is a major issue for us. However, from year to year, there is variation in the size of the increase from trust area to trust area. That variation is growing, so there is a gap between the South Eastern Trust and the trusts with a lower proportion of older people, which could be as wide as 15,000 people over 65 years of age by 2019. That represents a differential demand on health and social care.

Are we reducing bureaucracy and management costs in accordance with the review of public administration (RPA)? Senior management includes assistant directors, directors and chief executives, and we have reduced our senior management costs by 30% since the review. That has happened despite the fact that the South Eastern Trust is the only trust to have had two legacy trusts, and we had only two chief executives, two directors of finance, and so on. All the other trusts had three or more legacy trusts. However, we have achieved a 30% reduction in management costs. Over the period since the review, we have experienced a slight increase in total staffing, so that the number of front-line staff has increased slightly. Management costs have been a feature of each of the presentations by the trusts. Those costs in the South Eastern Trust are running at 3·4%, which we believe to be the lowest in Northern Ireland. Included in that is senior management, human resources, finance, IT and planning staff. Were we to remove all those staff, that would give us 3·4%, but clearly that is unfeasible. The idea of taking 9% CSR out of management costs is, as you can see, impractical.

By any of the indicators — length of stay, day case rates, percentage of administrative and clerical staff — the productivity of the South Eastern Trust compares favourably with the other trusts. There is a significant increase in demand, which is linked to the increase in the older population. We have broadly the same number of staff, with a slight increase in the front line, and all our productivity figures show that we have significantly increased our outputs —that is, the number of patients we treat per member of staff. Therefore, productivity improvements in the

South Eastern Trust are above the Northern Ireland average.

A key issue is the increase in demand. In hospital activity, there are significant increases in inpatients, day cases, outpatients and A&E department attendances. Were we in England, with a PCT-type commissioning arrangement, we would receive up to £10 million more than our current income for that level of work. However, those funds are not available to us.

I return to the issue of an increase in demand. We envisage a 74% increase in complex discharges from hospital. We envisage 10% more care management and 20% more domiciliary care. There is a significant additional demand on the South Eastern Trust because of the increase in the older population. The same is true in children's services: we have more referrals, more case conferences and more children on the child protection register. All that is set against a small increase in staffing levels. Therefore, we have increased the productivity of our staff. They are doing more, and that puts them under more pressure.

That is a quick canter through our position. I wanted to draw out those four or five key themes. They are at the root of what Neil will talk about — namely, our financial position. We have hit the targets, and we plan to do the same this year. However, we are doing that in the context of a significant increase in the population of older people, which places heavier demands on our health and social care. Hence the need for a 3% to 4% growth in real terms, as suggested by the Appleby report.

Neil will take us through the history and detail of the CSR, our consequent financial position and how that leads into our plans for the remainder of the CSR period.

Mr Neil Guckian (South Eastern Health and Social Care Trust):

I will quickly talk members through the different elements of the trust's £37 million CSR challenge.

RPA savings refer to management and administration costs. The year 1 element of the RPA — £2·921 million — focuses on management costs and associated issues, and year 2 — £2·921 million — focuses on front-line administration. Year 1 efficiency proposals were achieved by reducing management costs through mergers. Year 2 proposals are related to efficiency and changing the way in which we deliver our services.

Workforce control concerns the trust carefully scrutinising any vacancies in non-essential posts and ensuring that, at all times, it challenges any appointments. It concerns recruitment control and recognising the fact that salary and wage costs are the largest element of our total costs. It also concerns controlling our agency, temporary and bank staff. That is underpinned by strategies that focus on reducing sick leave, turnover of staff, and so on.

The main areas of change in service redesign and re-profiling focus on four operational directorates. In hospital services — we have spoken about those previously — it is about reducing lengths of stay, moving people from inpatient status to day case, and subsequently from day case to outpatient status, thereby creating faster pathways and improving productivity, including safety and quality of care. In services for older people, the main focus is on enhancing rehabilitation services, thereby increasing domiciliary care to reduce reliance on institutionalised care and ensuring that long-term decisions are made at the right time on the pathway for patients and clients. Our overall strategy is to reduce reliance on institutional care.

We have a series of detailed proposals on mental-health services. First, the trust wishes to develop crisis response and home treatment, which will improve services and reduce reliance on long-term services. Secondly, the trust wishes to develop psychological therapies and provide alternatives to inpatient care through community-based crisis centres, and, in partnership with the Belfast Trust, to rationalise the older psychiatric hospitals to create an eastern area approach to mental-health and disability services.

In children's services, I want to highlight the enhancement of foster care services to reduce the reliance on residential care.

We also have efficiency proposals concerning the voluntary sector. Those proposals involve an examination of major contracts and accepting that, with small contracts, organisations will experience difficulty in improving efficiency. However, with contracts that are above £20,000, we believe that partner organisations can work with the trust to improve efficiency in their service level agreements.

"Non-pay" refers to regional approaches to procurement and pharmacy that have been brought into the trust.

The final area of CSR proposals is based on a small element of income generation.

The trust performed excellently in year 1 of its savings targets, achieving 95% on a recurrent basis. In the current year, we are still working through our agreed plan to achieve savings. However, we are optimistic that the trust will achieve those targets in-year and maximise that achievement on a recurrent basis by 1 April 2010.

However, as the chief executive said, it is an incredibly challenging year financially. In the current year, the trust has a projected deficit of £10·5 million, and the reasons for that have been presented to the Committee by the chief executive. The main elements of that are due to delays in efficiency savings. I emphasise that those are delays and not non-achievement; we are where we are. Service pressures make up approximately £4·5 million of that £10·5 million deficit. Some of those pressures are historical, and some are new this year.

The trust has a three-strand approach, which is carried out throughout the organisation. There is an efficiency programme, which we presented; there is a contingency plan, which has gone to the Minister and to the Department; and there are general cost management approaches, which any organisation would consider taking to minimise costs.

The main elements of the trust's contingency plan are a reduction in pension costs — the Minister made an announcement about that — through independent actuarial valuations across the UK; delayed service developments, most of which are naturally occurring delays due to the recruitment process, because it takes a number of months to get people into post; a reduction in non-payroll costs through cost management; a commitment to maximise agency control and to minimise payroll costs; and a focus on further income generation by bringing forward our CSR proposals for next year.

We are also considering reducing the cost of redundancies and early retirement on the administration side by maximising redeployments, although that has not yet been approved. We are in consultation with the Department about that. Given that there have been more vacancies and agency opportunities for that over the past few years, we believe that it is possible to save a significant amount of money. We also aim to accelerate next year's comprehensive spending review proposals. However, I emphasise that that is only 5% of our total contingency plan

actions.

I do not propose to go into detail about cost management, because the issue relates to the same issues that we spoke about earlier: continuing to scrutinise vacancies, to review all posts and to constrain all non-essential and non-payroll costs. It is about everybody working together to reduce costs throughout the trust.

The Deputy Chairperson:
It was remiss of me not to congratulate Hugh on his new post at the start of the session. Is this is the first time that you have been a witness at the Committee in this capacity?

Mr McCaughey:
It is.

The Deputy Chairperson:
I will later call the three members who represent constituents in the South Eastern Trust area.

The trust met its break-even duty last year and is on target to do so again this year. An issue for the Committee is about whether the break-even duty restricts trusts. What difficulties does that duty cause, and would you like a change in how it works?

Mr Guckian:
If the approach were to change, it would be a mixed blessing. We always assume that the following year will be easier. Not having to break even would be acceptable if the deficit were not added to the following year's burden. However, that is unlikely to happen given that we are talking about public finances.

The approach is probably as good as we can think of at the moment. However, a three-year planning cycle with built-in flexibility would be ideal, rather than having to achieve exactly zero to break even. I would prefer if there were some more tolerance about the break-even duty, rather than simply a blanket "yes" or "no" to break-even.

Mr McCaughey:
We also believe that efficiencies can always be made and that the potential exists for us to do

things differently; hence, the reform programme. The scale of the change required during the three years of a CSR period is unprecedented, given that 3% efficiency savings must be found consecutively each year. The speed of change is challenging. Neil mentioned that the financial planning cycle makes it difficult to start some of those issues early in the year.

The Deputy Chairperson:

You said that one element of your contingency plan is to reduce the cost of redundancies. We all know that early retirement and voluntary redundancies are expensive measures. How many staff do you expect to lose through voluntary redundancy up to the end of this financial year? Do you have those figures to hand?

Mr Guckian:

I do not. However, we expect the number of voluntary redundancies to be small because we are focusing on administration posts. Our administration savings for this year are £2·9 million, £400,000 of which has already been achieved through allied health professional services as well as an element of goods and services. There is approximately £2 million of administration salaries and wages; if that is divided by approximately £25,000 — my maths will let me down at the very last minute — a maximum of 80 posts will go. However, all 80 of those staff members will not receive early retirement or voluntary redundancy packages. Usually, only some 20% would receive such packages, and the trust is optimistic about minimising that number into the low teens during this financial year.

The Deputy Chairperson:

Are there any staff members who want out but cannot get out?

Ms S Ramsey:

The Committee is looking at them. *[Laughter.]*

Mr Guckian:

The trust must always have an eye on the public purse. Certainly, there are people in that position; however, people's expectations cannot be matched by the money that the trust has available for redundancy and retirement packages. That must be accepted. Ideally, everyone's expectations should be met, but, if the trust can redeploy staff elsewhere, it is not right that they should be paid an enhanced rate to leave. It is not always possible to redeploy someone who has

worked as a senior manager for many years, but many of those who work in more generic administrative roles can be redeployed successfully. However, some of those staff will receive retirement or voluntary redundancy packages.

Mr McCaughey:

The trust is examining that area. As Neil said, we are dealing with public money. We have held back many vacancies over the past few years, which affects the amount of money spent on agency staff. That is why we did that, which allows the trust to be more flexible in its approach to staffing.

Mr Easton:

Is the trust confident of making up its £10 million deficit?

Mr McCaughey:

Yes, it is. It will be tight, but the trust feels that it can make up that deficit with the plans and proposals that it has in place. However, it must deliver everything in its plan, and that does not allow for much contingency.

Mr Easton:

Do you expect to use the Department's controlled fund to meet that deficit this year?

Mr Guckian:

The trust has not been given access to the controlled fund.

Mr Easton:

Do you know what that fund is?

Mr Guckian:

No, I do not.

Mr Easton:

The Northern Trust knows about that fund, yet the South Eastern Trust does not.

The trust's original efficiency savings were agreed by the Minister. However, did you say that

you have also created a supplementary set of efficiencies?

Mr McCaughey:

No, we have not. The three-year CSR proposals were approved by the Minister earlier this year and taken to the Assembly. The supplementary proposals in the trust's contingency plan were introduced to balance the books in-year, because of other financial pressures and slippage in some of the CSR proposals. That is the distinction between CSR efficiencies and the contingency plan.

Mr Easton:

Is the trust still reducing the number of its nursing staff? I am aware that there are no planned redundancies in that area, but is the trust still replacing some of those positions?

Mr McCaughey:

No. There has been a slight increase in the number of nursing posts in the trust in the past two years.

Mr Easton:

Therefore, there have been no sneaky reductions?

Ms Charlotte McArdle (South Eastern Health and Social Care Trust):

The trust has increased the number of its nursing staff for two reasons: when the trust compiled its CSR proposals, they were still proposals. It is hard to be accurate about the number required until the detail is worked out, and increased demand has necessitated an increase in nursing staff. For example, there has been an increase in the number of nursing positions in the maternity unit of the Ulster Hospital, because they have experienced a much greater birth rate than was initially anticipated. Furthermore, the trust has put additional resources into crisis response and home treatment in mental-health services, both of which are nurse-led. Moreover, a 24-hour nursing service has been developed in the north Down and Ards area, which was not available before I came into post. Those significant developments to meet demand have enabled the trust to maintain and grow its nursing workforce over the past two years.

Mr Easton:

The arrangements about nursing sisters in outpatients have not yet been sorted out under Agenda for Change. I would like that process to be quickened up. I have caused the trust much angst

over the issue, but the staff have still not received their money. Does the trust use taxis for medical records, patients and moving material around? I know that the Northern Trust does.

Mr Guckian:

Our highest taxi usage is accounted for by children's services and relate to court access orders. It amounts to a high and increasing cost to the trust as courts grant more such awards, particularly in cases in which different parents have access awards to children who live at independent and neutral venues. Those cases sometimes require the child and parent to travel by taxi. Every directorate has taxi costs, but, as with all other costs, we are reviewing and trying to minimise them. However, taxis are a high cost to the trust.

Mr McCaughey:

Rationalising the use of taxis and other forms of transport is one of the work streams that we are considering with a view to reducing expenditure. It is an area in which we hope to make in-year savings.

We want to conclude and resolve all the Agenda for Change payments and bandings as quickly as possible; we are committed to doing that.

Mr McCallister:

You are very welcome. Congratulations on your appointment, Hugh.

On the general theme of efficiencies and their effect, you have described their impact and the rapid growth in the trust's services for older people. There is a debate in my corner of the trust's area about the withdrawal of many of those services at facilities such as St John's residential care home in Downpatrick and Grove House in Ballynahinch. What is your response to that? The trust states that the replacement for St John's is on target for summer 2010. Will that definitely happen? Have all the issues about the location of the replacement been sorted out? There is some doubt locally about where the replacement will be sited.

Mr McCaughey:

I will ask John to talk about the replacement for St John's.

There has been much growth in the additional services for older people that we are creating in

the community. That includes elements such as sheltered housing, the replacement for St John's, care management packages and domiciliary care. That is part of the strategic change and reform programme that we are trying to achieve, and that is why growth is being seen in those areas rather than in residential facilities, from which we are moving away.

Mr John Simpson (South Eastern Health and Social Care Trust):

I am happy to report that we have been working closely with the Housing Executive and others, including Trinity Housing Association, and everything is now in place. Final financing approvals have been given in the past week or two, and we expect to go on site within a few weeks.

There was debate about Bridge Street and other locations, but they were only possible locations, and they were not actually available to us. The opportunity to secure that development was urgent, and we have now done that. We have to work with other agencies to ensure that we rule out or minimise the impact of any negative aspects of this location. We must consider issues such as antisocial behaviour. Certainly, we would like that to be removed rather than acceding and losing the opportunity to secure the development. Supported housing developments are the way forward, they are what people want, and we are keen to see them in place.

However, the trust has experienced a 20% increase in domiciliary care packages, which is significant and is a message that does not get out often enough; we are doing a great deal in that regard. Thus, there has been an increase in care packages, but the level of domiciliary care has also risen. It is important to note that we are exceeding our target to provide 45% of care in the community; about 52% of care packages are provided in domiciliary settings.

Mr McCallister:

Is there a waiting list for domiciliary care packages?

Mr J Simpson:

We are meeting our targets. We are charged with completing assessments within eight weeks and with having the core components of care packages in place within 12 weeks, and we have been meeting those targets for some time.

Ms McArdle:

There is no waiting list for care packages. On occasion, we might put a base package in place

that allows someone to stay at home safely, and then we build it up over a period of weeks, but nobody has to wait for a full care package.

Mr McCallister:

It is worth noting that there are still replacement concerns, and work remains to be done. Charlotte made arrangements for me to visit St Paul's Court assisted housing scheme in Lisburn, which is an excellent facility.

Your administration costs of 3·4% are also excellent, and one of the surprises in this process has been to discover that all the trusts' overall administration costs are lower than most people expected.

You are developing other new services, including those at the new Downe Hospital, where you must ensure that facilities address community anxieties about matters such as urgent care, the A&E unit, staffing levels, the fact that there are problems in the hospital even though it has not yet been open for five full months and whether the midwifery-led unit is still on target to open by spring 2010. There are also concerns about the lack of a stroke unit in the Downe Hospital. It seems bizarre that the hospital provides all the services of a stroke unit, but there is no "stroke unit" sign on the door. It seems strange to people in the area that they must bypass that facility to receive treatment at the Ulster Hospital. If services exist in the Downe Hospital, it should have a dedicated stroke unit, and you should consider that as you develop services in the locality.

Mr McCaughey:

Charlotte will pick up on the point about the stroke unit, and I will respond to the other issues. I have seen people's concerns about the A&E unit being expressed in the papers, and I have had queries about it. We are committed to having a medical-led emergency department, and that is not in question. Nevertheless, as you mentioned in your second point, we continue to have staffing difficulties. We have eight junior doctors to fulfil the rota, and, at any one time, four or five of them are in post, which presents problems in filling all the rota slots. That has been a growing problem for us, and, on occasion, we have had to fill slots late in the day. Therefore, we need to consider a model for a sustainable medical-led emergency department that affords us greater staffing stability and certainty that those members of staff will be present.

Mr McCallister:

Therefore, it is definitely not about cost.

Mr McCaughey:

No, absolutely not. We have seen other instances throughout the Province, such as the gynaecology department in the Erne Hospital, which found it difficult to recruit junior doctors. I want to ensure that we get stability in the service so that we can guarantee its continuity and quality.

You also mentioned an issue with the midwifery-led unit, which, again, involves staffing. We needed to fill eight additional posts to start up the unit. We have been trying to fill those posts, but, although we have recruited some people, we have not yet filled all eight positions. Therefore, we want to rerun the recruitment process, and we aim to establish the service, probably by spring 2010, using whatever staff we can recruit by then. We are considering what model we might use to do that. The trust is committed to getting that service off the ground.

Ms McArdle:

The staff of the stroke unit have been trained and have expertise in looking after people who have had strokes. That service has grown in the past year, and, recently, the trust was able to advertise the allied health professionals' support for that by way of occupational therapy, speech therapy and physiotherapy. What is exciting about the Downe Hospital is that it has an in-reach/outreach model for rehabilitation. The staff in the community are working with those patients to get them home earlier, and a full range of services is available to them when they get home. The trust has been able to do that only in the past few months.

The bypass to the Ulster Hospital was mentioned. To deal with the need for immediate treatment, there is a regional agreement for the provision of lysis treatment, which includes dealing with strokes. At present, the Ulster Hospital is the recognised site for stroke treatment; again, that service started this year. There will be money upstream for developing that service, and consideration has been given to deciding which hospital sites would be best placed to deliver that treatment. Only a small number of patients is suitable for that treatment, but it is a question of access to the right decision-making and the right pathway for the patient. That might mean that those patients are triaged and then referred back to the Downe Hospital as quickly as possible.

Mr McCaughey:

I will make another point about the Downe Hospital. The new building has given the trust a tremendous opportunity. There were many headlines about services being discontinued, but new services have been introduced. For the first time, cataract surgery is available at the Downe Hospital, and bowel screening will be available temporarily for two to three years. A new colorectal cancer surgeon is undertaking day case endoscopy work at the hospital. That service is being delivered with a higher level of skill and expertise than was available previously.

Many new services are being introduced that were previously unavailable locally; the challenge to the trust is to continue to find ways of adding new services rather than allowing the focus to be on the services that have been taken away. The key to that is the network of hospital services and other facilities across the South Eastern Trust area and networks with other trusts. The new colorectal surgeon is providing his expertise as part of a networked service across from the Ulster Hospital into Downpatrick.

Mr McCallister:

I was going to ask about dialysis.

The Deputy Chairperson:

I have given you plenty of leeway, John.

Mr McCaughey:

There are no plans at present for dialysis. It would not be economically feasible or likely to happen. There is a growth in demand across Europe for renal dialysis. We would not rule it out in the future, but I do not want to encourage false hope. If it is going to happen, it will happen down the road a bit.

Mrs I Robinson:

It is nice to see you and your colleagues again, Hugh.

I am biased, of course, but I salute all that you are achieving. I know that the renal dialysis unit at the Ulster Hospital serves the wider community twice a day, every day. It is an amazing centre; those members who have not seen it should visit it. It would be nice to know that that

programme would be rolled out sometime in the future.

I note that the material that the trust has provided makes no mention of using the independent sector. I assume that that is down to elective surgery being performed at Lagan Valley Hospital and managing and utilising your theatre time to its full capacity. What is the trust's bed capacity at present?

Mr McCaughey:

In the Ulster Hospital?

Mrs I Robinson:

Yes.

Mr McCaughey:

As of earlier this week, the bed capacity was 574. We have had to use the independent sector extensively over the past few years, and we continue to do so this year to bring down our elective waiting times and meet that elective capacity. We work with the Health and Social Care Board to build the capacity into our services to deliver the demand for elective surgery. That requires some recurrent investment.

We know the areas in which there is currently a shortfall in capacity. Those are the areas in which we have to buy elective care from the independent sector because we do not have that capacity. It is not all about theatres, beds, and so on: it is about having the staff on the ground with the skills to do that. We work with the Health and Social Care Board so that we can build up that capacity because I want to see where the National Health Service (NHS), and the South Eastern Trust, has the capacity to meet the demand for our population.

Mrs I Robinson:

In the trust's CSR proposals, there is a nil return for all three years for the independent sector. Why are those figures not included?

Mr Guckian:

We consider the independent sector in relation to residential nursing care, which we have protected from CSR efficiency savings. We have not asked our nursing homes or elderly

people's homes to achieve 3% savings each year. We have separated the voluntary sector from the independent sector, so it is a different independent sector.

Mrs I Robinson:

That is confusing because I was going to ask — I asked the same question of the Northern Trust earlier — whether you have considered utilising the private sector, but using NHS theatres through the night, and so on, to reduce your lists. It would be cheaper than using the private, independent sector and their theatres. Costs would be cut because NHS theatres would be used.

Mr McCaughey:

An independent sector provider uses the facilities at the Ulster Hospital. We constantly consider different models, ideally ones that the trust can provide. If that cannot happen, the independent sector provider uses our facilities on the basis that they ought to be cheaper. The trust will save money because we use our estate and fixed assets, and, where we do not, we use the independent sector facilities.

Mrs I Robinson:

What is your bed occupancy? Will you assure me that all efforts are being made to ensure that there is a professional and caring mental-health service in the Ulster Hospital complex rather than at the mental-health unit at Ards Community Hospital, which, as Hugh knows, is well past its sell-by date? That is the nicest way that I can put it.

Mr McCaughey:

The percentage occupancy changes from quarter to quarter and from month to month.

Mrs I Robinson:

The only reason why I ask is that I would be worried if the current percentage is high. We hear so much about swine flu, particularly for elderly people. There are many young children with special needs and learning disabilities in your catchment area, so I wonder how you intend to cope.

Mr McCaughey:

We have spent much time in the past six months on our swine flu preparations. We have tested our plans against other trusts, both locally and further afield. We recently carried out a tabletop

exercise in which we tested those plans. If the swine flu surge happens, we have a range of measures about how to cope and how to cover vacancies. Those scenarios are included in our plans.

Mrs I Robinson:

What about the mental-health unit?

Mr McCaughey:

I will ask John to comment on that.

Mr J Simpson:

We are certainly aware that the facilities in Ards are less than we would desire, and they have been for some time. We have flagged that up, and we have proposals to consolidate on the Ulster Hospital site.

We work with other providers — in the Belfast Trust, for example — and consider what we can jointly provide as a single facility to maximise our local facilities for issues such as continuing care. Work is ongoing, but it is not yet complete. We recognise the issue.

Ms McArdle:

The inpatient unit moved earlier this year from Ards Community Hospital to a newly furbished unit at the Ulster Hospital. I agree that the accommodation was less than standard, and the new accommodation is much better.

Ms S Ramsey:

I have the pleasure of representing a constituency, part of which is in the South Eastern Trust area, including the Twinbrook area, where I live. You are welcome. You said that you had met the vast bulk of targets, which leads me to ask if efficiency savings are hitting front-line services? If you have met the vast bulk of the targets, that is an issue. You also said that you believe efficiency savings are to be gained. Do any of the panel believe that, if reform and modernisation and efficiency savings had happened years ago, it would have saved millions of pounds in the Health Service and the public sector? Do you believe that spending public money, especially in the Health Service, was not wise?

Mr McCaughey:

We have tried to avoid making efficiency savings that take resources away from front-line services. It can be seen from most of the CSR proposals, and any actions that we try to take in-year, that we try to avoid those having an impact on front-line services. We try to prioritise that. More money must be saved, so there will come a point when front-line services are affected. The contingency plan that Neil outlined, and that sort of recycling and superannuation benefits that have come about, will mean that we can avoid hitting front-line services in-year.

Demographic growth is always a challenge. We can recycle money and continue to hit the current level of service while delivering efficiency savings. The demographic picture in the background and the growing demand from the increasing elderly population put pressure on services, which fuels the Appleby theory.

Ms S Ramsey:

Does that not mean that funding could be increased through the capitation formula because of the age of the population in the South Eastern Trust area?

Mr McCaughey:

We are not receiving increased capitation.

Mr Guckian:

That formula does not generally keep pace with quick changes in population.

Ms S Ramsey:

Is it the case that, because the elderly population is increasing in the South Eastern Trust area, the trust will receive additional funding according to the capitation formula?

Mr Guckian:

We would get acceptance of our core population and an increase in our income. However, the capitation formula is not designed to keep pace with rapid changes in population. Our presentation to the Committee shows that we have clearly delivered more services. Our front-line people deliver those services, and, since 2006-07, in acute services, we have delivered 20% more inpatients, 6% more outpatients and 13% more day cases with minimal above-inflation service developments. We strongly believe that we have protected front-line services as much as

possible, but they are affected. It is about modernisation and reform; it is not reducing but changing the way in which we do things.

Ms S Ramsey:

You have to be commended for that. Making efficiency savings does not necessarily mean a cut in front-line services.

Mrs I Robinson:

Good point, Sue.

Mr McCaughey:

That is true up to a certain point. We can deliver a certain amount of efficiency at a certain pace. If it goes beyond that, it will begin to affect front-line services. The Appleby report suggests that between 3% and 4% of real growth is needed. I suppose that that view is evidenced by the growth in population. A population of older people equivalent to the population of Ballynahinch is added to the Province's population of older people every year. That places greater pressure on the health and social care system, and that is where the driver for real growth comes from.

You asked whether efficiency savings should have happened previously. They have been happening; since I came into the Health Service, there has always been a defined sum of efficiency savings. The current rate of 3% is unprecedented, and none of us is looking forward to the next CSR period; the potential implications of that concern us.

Targets for efficiency savings have been in place previously. Shortening lengths of stay, increasing day case rates and consideration of different ways of doing things are nothing new in hospitals. Twenty years ago, children who were in hospital to have their tonsils removed stayed in for a week. In many cases, that can be done as a day procedure and involve a short stay. The changes have been happening, but the pace at which they have been happening is unprecedented.

Ms S Ramsey:

Do you agree that the spending of public money in the Health Service was not always wise?

Mr McCaughey:

You would not expect me to.

Ms S Ramsey:

I am quoting from the previous presentation. I will not push you, in case I need the services.

Dr Deeny:

Are you ready and thinking ahead for the great move from looking after people in secondary care to looking after them in the community? That move is well on the way. John mentioned care packages, and many people think that community care is more expensive. That has to be thought out.

The Forward Steps programme, an early intervention service for preschool children with autism, has been brought to my attention. The programme is important for families to learn about their child's disability and how to work with them, and it provides family support. I understand that, along with other trusts, the South Eastern Trust provided some £25,000 a year to the Forward Steps programme and that that has been withdrawn. Is that correct? It is not a huge amount of money when compared with the millions of pounds in other areas. The community care that disabled children receive at preschool age is important, for the parents and for the children. If it is correct that that comparatively small amount of funding has been withdrawn, how can you justify that? It would leave a gap before kids go to school.

Mr McCaughey:

None of us has knowledge of that; I would need to research that and come back to you.

Dr Deeny:

I would appreciate that. The people from the Forward Steps programme have approached me about that as a doctor, and I said that I would raise the issue.

Mr McCaughey:

I am happy to come back to you, but I will not try to give an answer on an issue of which I am not aware. On the greater scale, it is not a huge amount of money. I will find out what the issues are and come back to you. Charlotte will answer the question on secondary care.

Ms McArdle:

Our figures demonstrate the increasing demand and the increase in complex discharges from

hospitals, which have increased by 75%. That means that we are looking after more complex cases at home. People are being nursed and maintained at home, who, five years ago, would not have been able to be sustained at home. People with tracheotomies, continuous positive airway pressure (CPAP) machines and all sorts of other assisted breathing apparatuses are being cared for at home quite successfully. That did not happen previously, so the increase in complex discharges is definitely an issue. The move from secondary care to primary care means that we divert resources, mainly from nursing and rehabilitation, to primary care to enable us to work with those discharges.

We also prevent hospital admission through programmes such as the tele-health monitoring of chronic disease, respiratory failure, heart failure and diabetes. There is much more that we can do in that regard, but the South Eastern Trust has been proactive in its tele-health monitoring. We monitor about 500 people at home through chronic-health programmes. In addition to that, there are 25 individual community care schemes that help to keep people at home safely. "Safely" is the key word, because there is no point in us keeping people at home if they are constantly in and out of hospital.

The trust has a rehabilitation programme, and we are conducting research on that. It is about affording everyone the opportunity of a rehabilitation programme before we make decisions about their long-term care. We believe that, where possible, rehabilitation at home has greater benefits for the patient than rehabilitation in an intermediate care centre. It improves patients' independence and living ability and reduces their long-term care needs. We have tried to factor that into our proposals. Complex discharges are expensive, and it is becoming more expensive for us to look after people at home. Therefore, we must ensure that our services are efficient and effective and promote our clients' quality of care and quality of life.

Mr McCaughey:

Charlotte has talked largely about older people, but the same principles apply to mental health. In mental health, there has been a shift from the institutional or hospital-based model to community alternatives. As part of my induction, I recently had an opportunity to look at the services in Downpatrick. It was powerful to witness the present community models compared with the old wards and old-style services that were in place 10 or 15 years ago.

I also had a chance to meet some of the service users. We can talk about issues such as crisis

response, psychological therapies and community-based alternatives, but it is powerful to meet the people who use those services and whose lives are made better as a result. I do not know whether you have received it yet, but we issued an invitation for the Committee to hold one of its meetings in the trust or, indeed, to view the services. The services are contained in a tight geographical area, and it is powerful when you see them in operation.

Mrs Hanna:

You are welcome to the Committee; thank you for your presentation.

The South Eastern Trust seems to be working through its efficiency savings targets quite well. You mentioned a 30% reduction in management costs and redundancy packages; perhaps you will say a little more about that. You also talked about enhancing rehabilitation services and providing more primary care. Has there been any reduction in the number of acute beds? I want to ask about PCT. I am not sure what those letters stand for, because I do not like acronyms. Will you explain your comment that you would get 10% more resources if your trust was in England?

Mr McCaughey:

I am sorry for using acronyms; I have tried to train myself not to use them. PCT stands for "primary care trust". Under the commissioning model in England, money follows the activity. English hospitals have benefited from that and experienced growth in their activity. Under the English model, we could probably have expected to receive up to £10 million more for our acute work.

I will ask Neil to address your point about the 30% reduction in management costs, and then I will speak about the number of acute beds.

Mr Guckian:

We have reduced costs at high-management level by 29%. It is remarkably difficult to demonstrate the financial savings through our formal year-end accounts. However, we have carried out some work. In pure money terms, our actual management costs have gone up. For example, the pension costs for all staff in the Health Service have gone up substantially over the past few years. When one allows for that, along with the one-off Agenda for Change elements to which we referred earlier, and normal inflation, we can demonstrate that our management costs

have reduced by 15·5% in 2008-09.

Mrs Hanna:

Do you anticipate a saving?

Mr Guckian:

With regard to our funding, that is real-term money on which we are able to make savings for the trust.

Mrs Hanna:

Do you see that as a saving in the new set-up that you have already made?

Mr Guckian:

Absolutely. We can demonstrate clearly to any external person that we had a minimum saving of 15·5%. We analysed it, and we could identify more, but that would cost some management time. The saving of 15·5% was at the end of March 2009, and we are only partly through our RPA. However, that is the main management element. The remainder of the savings will be front-line administration and will be saved in this year and next year. There is likely to be some tail-off into next year to achieve the full-year effect. However, it is a matter of record, and we are proud of it.

Mr McCaughey:

You mentioned the number of beds. We are in a continual process of reducing lengths of stay in hospital. Rather than inpatient stays, we are considering day cases where we can offer new techniques, including laparoscopic techniques, and so forth, where people have a shorter length of stay or, potentially, be day cases. We are also considering community alternatives so that people are discharged from hospital more quickly. All that enables us to reduce the number of beds. There has been much discussion about beds, but the issue should focus on how many people we treat, and we are treating more people.

We are also offering new services that we did not offer in the past, we are using new drug regimes, and we are keeping people alive longer. Therefore, the focus on the number of beds is a distraction. The focus should be on the number of people whom we treat and the fact that we can treat a growing population, bearing in mind the number of elderly people being treated.

Mrs Hanna:

I asked about the beds because the Committee is being told that primary care is not a cheap option. However, we have been led to believe that it is cheaper than using acute beds. Do you agree with that?

Mr McCaughey:

In 1987, in the catchment area of the Ulster Hospital, there were 1,200 beds. There are now about 600 beds, but we treat more people. We offer new services that we did not offer previously, and we are able to treat illnesses that we were not able to treat previously. We keep people alive longer with a much higher quality of service. The service is much better than it was in 1987, and it is carried out using half the number of beds. The focus should be on the quality of service and the number of people whom we can treat and not on the infrastructure — that is, the beds that are used for the treatment.

Mrs Hanna:

You referred to the Appleby report, and we all know that that report is bandied about depending on what argument people want to make. Were Professor Appleby's ideas helpful on issues such as improved productivity?

Mr McCaughey:

There is a PhD in the answer to that question. People extract elements of the Appleby report that are helpful to them. The report was thorough, and it threw up a range of issues. However, there are probably elements of it that we do not feel are fair. Nevertheless, some of the underpinning principles, including the need for real growth in funding, coupled with demographic change and the growth in the older population and the implications of that, is a significant issue in the report.

The Deputy Chairperson:

Thank you very much for attending. Hugh, I hope that your first experience of appearing before the Committee was not too bad.

Mr McCaughey:

It was not too bad at all. Thank you.