Northern Ireland
Assembly

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Briefing from the Health and Social Care Board

10 December 2009

NORTHERN IRELAND ASSEMBLY

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

Witnesses:

Mr John Compton	)	
Ms Fionnuala McAndrew	)	Health and Social Care Board
Mr Paul Cummings	)	
Mr Hugh Mullen	)	

The Chairperson (Mr Wells):

I welcome the witnesses from the Health and Social Care Board. We have John Compton, who is very well known to those of us who represent Down District Council or Lisburn City Council; Fionnuala McAndrew, who is the director of social care and children's services; Paul Cummings, who is the director of finance, and Hugh Mullen, who is the director of performance management and service improvement.

John, it is likely that there will be too many questions for you to answer during the hour that

has been allocated, so we will probably send you a list of written questions. This is the first real opportunity that the Committee has had to meet representatives from the board, and over the months we have clocked up a lot of issues to put to you. You are very welcome. We hope that this will be the start of an ongoing relationship with your organisation, which is a crucial player in the provision of healthcare.

Mr John Compton (Health and Social Care Board):

Good afternoon and thank you for the opportunity to give evidence to the Committee. I also hope that this meeting will be the start of a constructive and long relationship between the board and the Committee. We are delighted to be here. You have made the introductions, Mr Chairperson, so I will spend a few minutes describing the board and outlining some of its core functions, so that it is clear what the organisation is about.

As members know, the RPA health reforms are well under way. The board was established on 1 April 2009 to replace the four existing health and social services boards. Our organisation's core functions are as follows: to arrange or commission health and social care for the population of Northern Ireland in line with DHSSPS policies, strategies and good practice; to manage performance of health and social care trusts and other providers to ensure that appropriate quality is available to the population to meet government targets and show an interest in achieving value for money; and to ensure that the £3·2 billion of resources per annum, for which we have some responsibility, is used in an economic, efficient and effective way in the commissioning of care. We also have regard for statutory duties and responsibilities, particularly in the area of social care.

Our board has been established. It is chaired by Dr Ian Clements and comprises seven non-executive directors and five executive directors. I understand that the names have been included in members' packs. We have made significant progress in filling our senior posts, and, over the next six months, we expect to complete the whole RPA change process. Our headquarters, which are in Linenhall Street, Belfast, also support two local commissioning groups, namely the Belfast and South Eastern groups. We also have local offices in Armagh, Ballymena and Londonderry.

Local commissioning groups have been established and they operate as committees of the board. They are coterminous with the health and social care trusts, and we hope that they will bring a local dimension to commissioning services for the population, within the framework of

the board, the Public Health Agency and the Department. Membership of the groups is now substantially complete. A few outstanding appointments must be ratified, but we expect that to be completed by Christmas or immediately thereafter. The groups are beginning to hold their first public meetings, and the Belfast group held its first meeting last month. I have provided diagrams showing the structure of the organisation. I hope that those are helpful.

We have undergone an enormous change, which has created all sorts of business continuity issues. Members will be aware that, as part of the reform process, we are expected to reduce our workforce from 521 to 400 by 31 March 2010. We are on track to achieve those targets. Voluntary redundancies and early retirements have been important factors in the management of that target. By the end of November 2009, 78 applications had been processed, and another 21 are in system. The annual savings will amount to £5 million, which will be reinvested year-on-year in service provision.

As a board, we must work closely with others, particularly trade unions, voluntary organisations, the Public Health Agency, which is our partner organisation, and the Patient and Client Council. Directors from our organisation and the agency are joint members of senior management teams. They work effectively with their boards and attend board meetings. Members of the public are welcome to attend any meetings, and, to date, meetings have been held in Belfast, Armagh, Derry and Ballymena. We plan to visit Enniskillen next month, and we will attend other venues as the year progresses. Our LCGs comprise local political representatives and voluntary and community sector representatives. We hope that that reflects the local flavour of the future direction of commissioning. We have a close relationship with trade unions and other phase 2 organisations on our negotiating forum.

Turning now to the tasks: commissioning, essentially, is to improve and protect the health and social well-being of the population in Northern Ireland. The principal vehicle for that is our annual commissioning plan, which we are in the process of producing for 2010-2011. It should make best use of the available resources. Over the next couple of months, we will work with agency colleagues and local commissioning groups to produce that plan, which will be a matter of public record and will go through the proper processes before it becomes public. We hope to have the plan completed and signed off by May 2010. That is the target for next year.

With respect to the efficient use of resources, which is of interest to us all, the board has a

responsibility, in legislation, to ensure that resources are used in the "most economic, efficient and effective way". I quote that, because it is important that that is what is outlined in the legislation.

The work of the board has the ability to reach everyone. We have an expenditure of £3·2 billion a year, which is just under £9 million every 24 hours. We spend a lot of money on the delivery of health and social care, but that expenditure is not always recognised. A further £600 million will transfer from the Department in 2010 for what is described as family practitioner GMS services and pharmacy services, meaning that the total budget will be approximately £3·8 billion.

We have engaged with trusts as an integral part of our responsibility to manage performance. Over recent months we have been made aware, as have members, that trusts have been under increasing financial pressure. We are particularly interested in the impact that that pressure might have on services, and we are working with our colleagues in the trusts and the Department to ensure that that has a minimal effect on the population, using our robust performance management.

Looking to 2010; although we have not had allocations, there are a number of givens that will cause difficulties for us all. Of course, we will have to continue to find efficiencies as a board and in the wider system under the requirements of the comprehensive spending review (CSR). Members will have had that debate on many occasions. There will be other pressures around, such as inflation, high-cost drugs, the revenue consequences of new schemes, and demographic pressures, that we have to factor into our commissioning plan.

A key element for us, as a board, is to support trusts in improving their responsiveness and efficiency, which they provide through a series of service improvement programmes, and hold them to account for achieving a wide range of standards and targets set by the Minister in his annual priorities for action. I hope that members are aware of the real and demonstrable improvements in performance over a number of areas in the past years. Where there were once unacceptable waits for hospital outpatient appointments for surgery, patient waiting times can now generally be measured in weeks. Furthermore, there has been a positive reduction in the number of healthcare-associated infections, and we are on target to achieve the regional target of reducing MRSA and clostridium difficile by 35%, compared with the 2007-08 year, by the end of

March 2010.

During the current year, much of the improvement has continued. There was a degree of financial uncertainty mid-year for trusts, when we had to decide what to do about swine flu, and that did create a small difficulty for them. Some of the recent performance reports show that we have lost a little bit of ground in some areas, including elective care and A&E standards. However, we expect those to return substantially through the year.

It is important to understand the scale of demand. There has been a 9% increase in demand this year on top of a 12% increase last year. Those are average figures; demand is much higher in some specialties. The ability of the system to absorb that level of increased demand is a reflection of the attention that we have paid to efficiency.

I am pleased to report that, as part of its commissioning process, the board has recently indicated to trusts a recurrent investment of £25 million in elective care arrangements to address capacity gaps. Further investment is planned in 2010-2011 and 2011-12, which will lead to the creation of approximately 270 posts: 55 extra medical staff, 90 nurses and 125 other supporting clinical staff — specialist nurses, psychologists and allied health professionals. The importance of this is that it signals a major change. It is a shift away from the non-recurrent use of money, and the investment shows that having a regional organisation brings benefits, because we are able to plan from a regional perspective and not simply from a geographical basis.

We have robust information systems and we monitor what is happening in some of our systems on a weekly and, in some cases, daily basis. Accountability is essential to ensure that standards are met and performance is improved. We have monthly accountability meetings with trusts, and, where there is concern, we have escalation arrangements that can be applied, including more frequent review meetings with me and senior officers; the placement of board staff in trusts, and the potential shift of activity from one organisation to another. I attend those meetings on a bimonthly basis, and the latest round of those meetings concluded this morning.

The board also works with the trusts to improve responsiveness and efficiency though a series of service improvement programmes. We are currently taking a number of those forward on scheduled care, elective care, cancer services, and unscheduled care, including A&E, fractures and ambulance. It is worth noting that we sometimes concentrate on things that do not work.

However, if you live in Londonderry, you probably have access to the best fracture service in the UK. We do many things in the Province that are at the top end of performance.

The area of social care and children is hugely important for us as a board. We commission services for adults, children and young people, which are set out in our commissioning plan. We lead multi-agency work with children's services' planning processes and produce a three-year children's plan. Much of the work that we undertake in our social care is required under legislation and we have statutory responsibilities to discharge. Over the past five years, there has been a 24% increase in the number of children referred to social services annually. In the past year, there has been a 20% increase in the number of children on the child protection register.

In respect of older people, there is a projected increase of 11% in the next five years and 40% by 2023. Therefore, we have a very ageing population heading our way. We are committed to providing support to people to ensure that they can live at home as independently as possible. That applies across all of the social care programmes. That gives us the opportunity to support projects such as the direct payments scheme and to increase how we give people the responsibility to provide such schemes.

Recently, we have had responsibility, as part of a team, in the management of swine flu. That has worked well. You reported earlier, and we are all pleased to note, that the number of swine flu diagnoses is dropping for the third or fourth week in a row. I am pleased to report that the overall uptake of the vaccination is very favourable in comparison with other areas in the UK. We are doing extremely well as far as that is concerned.

I want to reassure the Committee, because there has been some recent press coverage about whether a national disagreement with the BMA and GPs over the swine flu vaccination for children will create a difficulty. We believe that we have a route through that, and we are working with our GPs to sort that matter out. Where we have difficulty and are unable to do so, we will make alternative arrangements through our nursing services. We are confident that we will be able to work with our general practitioners, which is our preferred route. However, if that breaks down, we are confident that there will there will be alternatives.

In conclusion, I have given the Committee a quick run through a lot of issues. I am sure that it sounds as if I have been bombarding members, but over the past nine months, we have put a huge

amount of effort into getting the new board up and running. That has been done in partnership with the Public Health Agency. I look forward to a long and fruitful relationship with the Committee.

The Chairperson:

John, you have already headed one question off at the pass, and that was on the issue of GPs and swine flu. That was well anticipated. The session will be a bit of a miscellany, as there will be questions all over the place because so many individual issues have arisen. Many of them will try to tease out what control, supervision or direction the board exercises on the trusts, because the interface between the board and the trusts is crucial.

One issue that we have discussed this morning is the call for a public inquiry into the events involving the McElhill family in Omagh. The Committee is considering the issue, and the local MP for the area has called for an inquiry. Has the board given this any consideration, or does it have a view?

Mr Compton:

A public inquiry is a matter for the Minister to decide. Clearly, if there is one, we would participate fully. For me, the important issue in cases such as the McElhill case is whether we have the learning and understanding of what has occurred, and whether we are convinced that the actions we are taking will minimally reduce any likelihood of a similar event in the future.

I will pass over to my colleague Fionnuala who knows more of the details, but the Toner report has 55 recommendations. In the area involved — the west — 54 of those recommendations are well on the way to being implemented. When that happens, I think that we can have reassurance. The issue is one of ensuring that there is public confidence in the system and in the professionals who are working in a very difficult arena and environment. I do not think that it is for a board, per se, to have a view on public inquiries. Rather, we should respond to a public inquiry. If there is a public inquiry, we will facilitate and work with it. What we are really concerned about is the outcome and whether we have improved our childcare services.

Ms Fionnuala McAndrew (Health and Social Care Board):

There has already been reference to learning the lessons. We can ably point to the fact that lessons have been learned following the Toner report and certain actions have been taken to

ensure that we have a more robust child-protection service. In particular, John referenced 55 recommendations to the Western Trust, and 54 of those have been implemented. Many of the issues that were raised in the Toner report have been addressed, not just in the Western Trust area but regionally. Indeed, one advantage of having a regional perspective is that learning can be shared across Northern Ireland.

It is important to remember that this is very challenging work, as John has said. As a regional board, a lot of what we have been doing is to support trusts in the delivery of child protection services, bring forward things that will help them to do their work and support front line social workers. It is a challenging and difficult area of business, and social workers often get a bad press. It is important that we understand the difficulties that they face, so that we can encourage people into the profession and retain the very able and experienced professionals who work in that area of business.

The Chairperson:

Going to a different extreme, I want to talk about consultant and GP contracts. However, I do not know how we are going to deal with the matter with a GP present; Dr Deeny might want to leave the room. There are those who believe that the GP and consultant contracts are generous with a capital g, but we are more or less stuck with them for the foreseeable future. Has the board examined whether there has been value for money, and can anything be done to ensure that they are cost effective?

Mr Compton:

We look at the issue slightly differently. We are part of a national scheme, and pay and conditions are given to us nationally. It is in that context that we must assess whether we are getting value for money. If one looks at the changes in the performance figures for the acute sector and consultant side of the house, those indicate, on average, a fairly good performance. That is a measure of efficiency, and it has been possible to negotiate that in the context of the new consultant contracts.

One can have a view on whether it was underpaid or overpaid at a point in time; however, we come at the issue by seeing whether we can get value for money from the arrangement. We have reshaped quite significantly. We could not have got a lot of the performance arrangements that are now published regularly had we not changed how things happen as regards practice, working

patterns, and so on, in hospitals: that simply would not have happened. The consultant contract is one of the levers that can be used to drive the changes.

Much is said about general practitioners and whether they have the right contract. As a regional board, we want to use that contract. There are opportunities, through local enhanced services, to ensure that we keep the right services in local communities. We want to keep local commissioning groups in particular. As Dr Deeny knows well, those groups include general practitioner representation. We want to use the opportunities created by the contract to make services more tangible and more real in the local area.

We do not have the flexibility to negotiate the contracts. Everyone in the room will have a view on whether those were negotiated well or badly. What we have to do is use what has been negotiated to maximum effect and ensure that we are getting the best value possible for the service. I can give you confidence by saying that we are doing that fairly aggressively.

The Chairperson:

Another topical issue is the Foster report, which was published in GB last week. It analyses death rates per condition in A&E hospitals in Scotland and Wales. A general figure was given for Northern Ireland, but it was not broken down into figures for the various hospitals. Are the statistics for Northern Ireland available in a fashion that would facilitate that type of report to be issued here? Has the board given any consideration to issuing those stats?

Mr Compton:

Yes, those statistics are available, and, yes, we have considered issuing them. We have been working on that, and I will invite my colleague Hugh to speak about that in a moment or two.

Before anyone rushes to give out standardised mortality rate information, they have to be completely clear about what they are talking about. It is extremely dangerous to give out undiluted, undiagnosed evidence because it may give the wrong impression. Complexity may affect whether the mortality rate is higher or lower in a given hospital. There are a lot of variables, but we have given considerable thought to that.

Mr Hugh Mullen (Health and Social Care Board):

We see standardised mortality rates as being particularly important because we need to have a

good idea about what is happening. However, as John said, it is fairly complicated. The Dr Foster exercise in England, to which the Chairperson referred, was in gestation for about six months before anything was published: even then, it was quite contentious. We want to do a similar exercise, but we need to undertake our own validation checks when we have some data. We certainly expect something to be available in the first quarter of next year.

The Chairperson:

Being published?

Mr Compton:

It will come to us, as a board, and we will have to validate it, after which it will become public. We want to move to that sort of arrangement. Professor Jarman, who is part of the Dr Foster set-up, came across about six weeks ago and spoke to the board about his take on how that has worked. We are working closely in that regard, and that is the direction of travel.

It would probably be inappropriate for me to give a definitive date of when the findings will be made public, but we expect to have some form of public information during 2010. We do not have a date just yet because it is extremely important that the information is helpful and does not create any sense of ill-informed panic. The information has to be put out in a very measured and helpful way that allows people to understand what is being talked about. It would be highly inappropriate to just dump out any information in a raw and non-investigated way.

The Chairperson:

This is my final question, after which I will let members come in. Recently, the RQIA has provided evidence about hospital hygiene standards, some of which was encouraging and some of which was, frankly, dismal in certain wards in certain hospitals. What role does the board have in that whole process? Your paper indicates that the RQIA has a very direct flow to you, but is your role a supervisory one, or can you involve yourselves and instruct hospitals?

Mr Compton:

Yes, we can. Obviously, when we contract with any hospital organisation, we do so on a volume and quality basis. The patient environment has to be part of what we do. The whole issue of dirty hospitals or whether there are dirty hospitals is a question of balance. The fundamental issue is that the big success story is the drop in hospital-acquired infections. Those will drop by

35%, which is a huge sign of a different attitude and a different way of working in hospitals.

It is always a matter of regret if people come in and take photographs, and something horrible is shown or demonstrated. From our point of view, that becomes part of our discussion with the organisation at our accountability meetings. Ultimately, if it became a real issue for us, we could take certain actions on whether we would have that service delivered in that arena or environment. However, the important issue is hospital-acquired infections, which is a success story. I know that that does not carry the same political or photographic weight as a particularly unpleasant scene in a given hospital ward.

The difficulty with the RQIA inspections, which are done honestly and validly, is that they are a one-day snapshot. The hospital will get a phone call from the inspectors 30 minutes before they arrive, and they will go wherever they want to go on that particular day. It is a question of balance: does one judge a whole institution on what is found on one particular morning? That is not an excuse: we do not excuse what is not excusable. However, the hospital-acquired infections information is the point that should be concentrated on because that demonstrates definitively what is happening with regards to cleanliness and how people approach the whole cleanliness issue in hospitals.

Mrs O'Neill:

I want to get the role of the board clear in my head. One of the roles is obviously to performance manage trusts. This morning, as the Chairperson said, the Committee talked about child protection matters and the issue arose about the lessons that are learned. There were 77 recommendations in the overview report, 36 in the O'Neill report and 63 in the Toner report.
A lot of those recommendations are repetitive so, evidently, lessons have not been learned. However, I acknowledge that the trusts have made some improvements. When recommendations are made, is it the board's role to ensure that the trusts implement them?

Mr Compton:

Yes; indeed, we do more that that. For example, at today's accountability meeting, we went through a set of information to establish whether a plan was in place for every child who has been brought into care and whether proper and agreed plans were in place for handling every child who has been in care for six months. We go through the numbers, down to individual children, because such numbers are generally small. We make no apologies for considering individual

children, because we are dealing with important issues for each child and his or her family. We also look at issues for 19-year-olds who are leaving care, including whether they are in education or employment and how that sits in relation to 19-year-olds in the rest of the population. We look at the percentage of young adults who have been in foster care and who are now either resident with their foster family or on an extended-family placement to ensure that we do not simply put children through the system and say goodbye when they reach the age of 18.

All that information is heavily monitored, and we are improving and expanding the sort of questions that we ask and the detail that we are seeking, all of which leads to us take decisions about the actions or implementations that we want to see taking place in given areas or organisations. For example, we are closely involved with the South Eastern Health and Social Care Trust in relation to a particular area of childcare that has caused it particular difficulties and created complexities, and we are looking for assurances that it is taking certain actions that it indicated it would take and that that happens within the agreed timescales.

Mrs O'Neill:

You said that you are on target to produce the 2010-11 commissioning plan within the next few months. Local commissioning plans must feed in to that plan, but not all local commissioning groups are fully operational or have a full membership.

Mr Compton:

They have 90% of their membership.

Mrs O'Neill:

OK, but they are probably going to have their first public meetings in January or February. How realistic is it that they will be able to present you with a plan that takes account of local need?

Mr Compton:

We are breaking the system in, so things will get better as we go forward. When the organisation was set up last year, we simply had to inherit what was there and go with that. This year, we have an opportunity to shape and flavour the system and, next year, it will get better. We are very committed to developing the system; for example, we have carried out a major piece of work on patient involvement. It is a process; we are not going to fix everything perfectly in one go. However, there is a strong commitment to that process, and I believe that next year's product will

be much better than that which was available in previous years, because it will have regional flavour, which is a very important aspect.

When I try to explain in one sentence what we are trying to do, I say that we are about local services for local people, but safe and sustainable services for the population. Those two considerations drive and shape our thinking on how to organise services, and our commissioning plan invites input from organisations that will deliver those services. We are about the "what" and the providers are about the "how", but we have a very close interest in the "how" because we want to be sure that it delivers.

Mrs O'Neill:

An issue that the Committee raised was regarding allied health professionals being represented on commissioning groups. Are allied health professionals represented on all five commissioning groups?

Mr Compton:

Yes.

Mr Easton:

I would love to know about the board's plans for the 3% efficiency savings.

Mr Compton:

Our efficiency plans were set through the RPA. I covered that at the outset when I said that we are reducing our workforce from 520 to 400 people, which means that by 2011 we will have 120 fewer people working for us. That is the efficiency target that was set for us at the outset, and we are in the process of meeting it.

Mr Easton:

Is the review of public administration separate from the 3% efficiencies?

Mr Compton:

No; it is a total amount of efficiencies that are coming into the system that we have been given.

Mr Easton:

I thought that the review of public administration was separate from the 3% efficiency savings that were imposed by the Executive.

Mr Cummings:

The review of public administration is an integral part of the comprehensive spending review, which is an overall target. The review of public administration efficiency saving is one part of that target; it is separately monitored, but it is an integral part of the CSR target for trusts and the Health and Social Care Board.

Mr Easton:

Do you have 3% efficiencies as well as the RPA?

Mr Cummings:

We have higher efficiencies, because the review of public administration savings will mean an 18% reduction in our staffing numbers. Efficiencies for boards stand at 9%, a much higher percentage than the CSR target.

Mr Easton:

OK; that is helpful.

You heard the discussion that the Committee had on cancelled outpatient clinics. What is the Health and Social Care Board doing to try to address the cancellation of thousands of clinics? Should it set some rules about consultants cancelling clinics? For instance, could it be stated that clinics must not be cancelled to make way for study days? The board could rule that study days should be separate from clinics and that consultants who are taking a holiday should have a colleague cover for them. Furthermore, the board could rule that, because registrars are only a step down from consultants, they should be allowed to take clinics, thereby allowing the clinics to go ahead. Such simple measures to get to grips with the thousands of cancelled clinics would save money having to be spent on independent sector providers and would also keep waiting lists down.

Mr Compton:

The answer is yes, but my colleague Hugh will go into how we are doing that.

Mr Mullen:

At the beginning of the year, all clinic templates are set out for the 52 weeks of the year. All consultants are entitled to 10 weeks off work each year. That comprises 10 public holiday days, two weeks' continual professional development and their annual leave. Before we start the year, we do not know when those days will fall. Our first step, in conjunction with trusts, is to ask consultants for six weeks' notice of when they will be taking their annual leave. They usually know well in advance the days on which their study leave for continual professional development will fall. If six weeks' notice is given, we know which clinics will be cancelled and we will not necessarily have booked patients for those clinics.

So long as six weeks' notification is given by the consultants, we can work with the trusts on a system called partial booking. Following a referral, rather than an individual receiving a letter telling him or her to turn up at a certain hospital at a certain time, each patient is phoned to be told that he or she is on an outpatient clinic waiting list and asked what time, within a couple of weeks, and place would suit them for an appointment. That gives some ownership to the patients because, as you rightly said, the public did-not-attend rate is still too high. It is incumbent upon us to make sure that, as a part of the Health Service, our booking systems are fit for purpose, but it is also incumbent on the public to take responsibility for turning up when they have been given at least two weeks' notification of their appointment.

We have worked with each of the hospitals and trusts in setting up a partial booking system for all new outpatients. The next step involves some of the £25 million that Mr Compton mentioned. We are looking at how to improve our booking system for follow-up patients.

Mr Easton:

How many weeks of holidays did you say that doctors get?

Mr Mullen:

They get 10 weeks a year: six weeks' annual leave; two weeks' continual professional development; and 10 public holiday days, which fall between a Monday and a Friday. Each consultant is at work for only 42 weeks of the year, not 52 weeks. It is important to remember that. We have to plan our capacity on each consultant being at work for 42 weeks.

Mr Easton also said that specialist registrars should be able to take clinics. Specialist registrars are not allowed to see new patients unsupervised, but they can see follow-up patients. Therefore, if a consultant is not available, the registrar cannot see new patients. In that respect, we are observing the same medical education rules and regulations as everywhere else.

Mr Easton:

Nevertheless, there are thousands of cancelled clinics.

Mr Compton:

Looking back with respect to the clinics we would agree; however, the system that we will put in place will significantly improve that. When we meet trusts we want to know which and how many clinics have been cancelled.

We are all human beings and, occasionally, someone will miss a plane, be unwell or be involved in a car accident on the way to work. Such things are simply unavoidable. Nevertheless, if specialist clinics in a given facility are repeatedly cancelled, we will place our staff in the organisation to work out exactly why that is, and we will insist on certain things occurring inside that organisation. That will lead us to directly meet the clinicians involved, because there is no point in operating at arm's length. We must meet the people who are at the front end of the system.

People do not always appreciate the fact that consultants work 42 weeks a year, not 52 weeks. People ask why consultants have not been replaced or extra staff have not been employed, but that demand must be balanced with the number of people on a given team and the total volume of work that they need to do each year, so that each team has a viable workload. That is often a difficulty, particularly in smaller facilities where four, five or six consultants are working in a relatively small area. Although that would address the 10-week issue, the problem is that the actual volume of work is not enough for five or six people.

It comes back to having local services for local people and safe, sustainable services for the population. Those issues are driving a lot of the change. Equally, senior registrars do very important work in many clinics, but, ultimately, the clinical responsibility remains with the consultant, particularly for first-time referrals, which may involve important issues. To ensure that our and professional quality standards are met, consultants must review the final decision.

Mr Easton:

Yes, but there is no reason why a registrar cannot see patients who have been reviewed. Just because a consultant cannot attend, it does not mean that the whole clinic has to be cancelled.

Mr Compton:

I agree. However, the partial booking system, which is now very much a feature of our operations, is changing the dynamic of that. The partial booking system is designed to eradicate unplanned cancellations, in as far as that can be done. If we have repeated unplanned cancellations in an area, that is a matter for the board, and the board will exercise significant authority in relation to that.

The Chairperson:

We will probably ask you for more information on that, because the figures are quite startling, and they do not make good reading for all concerned.

Dr Deeny:

Fionnuala and gentlemen, you are welcome to the Committee. I want to get some clarification about how the board works with the Department and the Public Health Agency. Is the board doing jobs that were previously done by the Department? I see that Mr McClean from the Public Health Agency is in the Public Gallery; it is good to see him here. Does the board have a strong relationship with the Public Health Agency? Public health is becoming an increasingly important aspect of health provision, and rightly so. How strong is the agency's influence on the board in respect of future commissioning?

On the radio this morning I heard an admirable man called Bishop Hannon talking about Alzheimer's. He has recovered very well after two years of treatment, and it made me think that we are not getting patients checked out properly. Two people mentioned the fact that, on displaying the early stages of Alzheimer's, they were more or less dismissed by their GPs, whereas Bishop Hannon said that he feels better today than he did two years ago. We need to look at health promotion, disease prevention and quality of life.

My understanding is that the treatment that Bishop Hannon received is not available until a patient is seen by a consultant and is diagnosed following a scan, rather than a clinical diagnosis.

Bishop Hannon is a great example of how we can improve people's lives if we take action quickly and early. However, we need scanners to do that. If the Public Health Agency were to say to the board that the quality of people's lives can be improved if they are scanned early but there are not enough CT or MRI scanners in Northern Ireland, can the board influence the clinical decision on that?

My last question is to you, Hugh, and it is on performance management. How often does the board review the trusts? That may be in relation to clinical performance, hygiene or something else that impacts on patients' lives and health. If trusts are repeatedly carrying out unacceptable practices, what does the board do? Surely something must be done, so what power does the board have to deal with that?

Mr Compton:

The first thing to say is that the board does carry out some functions previously carried out by the Department. That is part of the system and it was always planned to be so. Indeed, the board will probably come to do a little more; for example, I mentioned that further resources will be transferred to the board to deal with issues that would previously have been dealt with at departmental level.

With respect to the agency, it would not be a question of it coming to the board and asking it to do something; rather it would be a question of a joint agreement being made between the two. The board is organised in such a way that, for example, Fionnuala and Paul attend the meetings of the agency's senior management team, and the director of public health and Mary Hinds, the senior nurse, attend our management team meetings. Therefore, the board has direct influence from the agency all the way through. Furthermore, the commissioning plan that I referred to requires agreement from the Public Health Agency's board and our own board and it is produced jointly.

The board is keen to see health improvements and primary and secondary prevention adequately reflected in how our services are shaped and developed. If a particular issue arose — for example, as Dr Deeny mentioned, in the area of secondary prevention of Alzheimer's — and if that were an agreed priority that sat within a policy, the board would shift its resources as much as possible to deal with that. If that meant that scanning services had to be bought and installed in two or three under-resourced areas, that would be done. However, those are difficult decisions

and must be balanced against competing priorities at any given point in time.

Commissioning is increasingly moving towards the requirement for an evidence base to establish whether a service actually delivers a result. Some may suggest that a particular service would be good to have, and it may well be, but it must also deliver a given result. If there is evidence suggesting that a particular intervention delivers a result, the board will be very interested in it, and we would look to our colleagues in the agency, as well as our own staff, to provide that evidence.

Dr Deeny asked about the board's sanctions, and Hugh can tell you more about how that function is carried out by the board. However, broadly speaking, the board's sanction function is quite strict. The board is not just a talking shop and it can put trusts on what they refer to as "special measures" and instruct them to do certain things in certain ways. That would only occur at the very end of a process involving a proper and responsible relationship between the board and the trust in question, but it can be done.

An example of such action being taken occurred in June this year in the Western Trust area when it became clear that there was an issue with how that organisation was using the independent sector, and it was told to stop using it overnight. There was a series of control issues that the board was uncomfortable with, such as the expenditure that the trust was generating and the cover for that, and the board, together with the trust, produced a recovery plan to work out how to handle the elective care issues. That produced a very good result and the board expects to see a very strong performance from that trust between now and the end of the year. The board has a very direct intervention role. Perhaps Hugh will now outline the board's routine and how it carries out that function.

Mr Mullen:

The board holds a range of meetings, and the ones that I hold are on a monthly basis. A meeting is held each Wednesday to discuss different issues. For example, one Wednesday elective care services will be discussed, and John has just outlined the discussion that we had with the Western Trust area earlier this year, which is an example of that. On another Wednesday we will discuss unscheduled care services, and we will consider what the Ambulance Service Trust is doing, what is happening with A&E services, as well as discharge arrangements. One week in the month we will consider what is going on with respected community services and allied health professional

services outside the hospital setting. We are trying to work with the trusts, because they want to run their services as efficiently and effectively as possible. We see ourselves working to improve things. *[Interruption.]*

Ms S Ramsey:

That is the Minister calling on the phone. *[Laughter.]*

Mr Mullen

We must be giving away too many state secrets.

On the fourth Wednesday of the month we have a follow-up performance meeting, in which I meet with directors, and every second month John chairs the meeting and the chief executives from each of the trusts attend. That is the formal mechanism that we have in place.

Mrs McGill:

You are welcome to the Committee; thank you for your briefing. I have just listened to what you said about the board going to the trusts every so often, and you also mentioned A&E. I am keen to hear what you have to say about the scenario that I am going to outline, which has been raised with me by more than one constituent.

I am concerned about the waiting time for a person who attends A&E at Altnagelvin at night. I can quote a particular case of one gentleman — a priority case — who had done absolutely everything that he should have; he contacted his GP and did everything necessary. He went to A&E at Altnagelvin and sat from around 6.00 pm until 2.00 am. I may not have the times exactly right, but it was something like that. He was a priority case, and was not well. He was actually in pain as he sat in A&E. How does the board deal with such a situation?

A second issue concerning A&E in Altnagelvin has been raised with me by a constituent. In the A&E in Altnagelvin there may be people who are under the influence of drink or drugs while young mothers are there with their young children. You mentioned earlier how the patient environment needs to be improved in response to a point about cleanliness that the Chairperson raised. That particular issue —

The Chairperson:

Being nice to the Chairperson will not stop him asking where the question is. Is there a question coming?

Mrs McGill:

I am just doing what everybody else is doing.

Mrs I Robinson:

You are building up the case.

Mr Compton:

I understand what Mrs McGill is saying. I know the problem only too well.

Mrs McGill:

It is a serious issue.

Mr Compton:

It is extremely serious.

Mrs McGill:

I did ask a question. How would the board respond to that situation? What can be done about people in A&E who are under the influence of drink or drugs? It is not about sectioning anybody off; it is about the experience of someone, who may have a young child with them, who has to endure that. What can the board do about that? One other point that I want to mention concerns the £8·8 million that the board spends each day. What is that spent on?

Mr Compton:

It is spent on the total health care system and the general medical services system in Northern Ireland, so it encompasses everything that happens.

It is quite timely that you bring up those specific issues concerning A&E, because, as I said, we have just finished our most recent round of accountability meetings this morning. Indeed, that meeting was with the Western Trust, whose representatives met the Committee earlier today.

We are concerned about the accident and emergency performance. The target is quite clear: it is for 95% of patients to be discharged or admitted within four hours of their arrival, and there should not be any 12-hour breaches. That hospital and others have had difficulties in meeting those targets. We have now asked hospital representatives to visit a unit in England that is similar in size and puts through the same number of people. In January 2010, we are going with them to see what can be learned from that unit, which regularly delivers the target of 95% in four hours on a clockwork arrangement. We want to improve understanding, so we are insisting that people go and look at that unit. We expect the outcome of that to be that the hospital's performance will be different.

That touches on a wider commissioning issue, which is how accident and emergency services should be commissioned for 1·7 million people. A configuration for commissioning those services is currently in place, and there is nothing more sensitive than talking about making changes to an accident and emergency system. If we are serious about considering quality, putting senior doctors on duty 24 hours a day and having a system that works quite well, it is probably a fact that the current configuration will have to change to be able to deliver that. By way of education and explanation, we want to talk to people about how we should move to a better service. It is not about money but about getting a better service. However, arranging that visit is a specific action that we are taking with Altnagelvin Hospital.

It is difficult to know what to do when someone is behaving badly at an A&E department, which is a difficult environment. Obviously, we have obligations to see or treat anyone who turns up, but there are expectations that people who turn up behave reasonably. It is difficult to put a boundary around that, because, despite the fact that someone may turn up having taken alcohol, they may have something significantly wrong with them. For example, a high proportion of people who present with significant head injuries have taken alcohol, so it is difficult to tell someone to come back when they are in a better state.

We try to make things as easy as possible, but I cannot say that those circumstances will not occur. Such situations are difficult to deal with. Our staff often work in taxing situations, and they try to deal with such matters in a sensible way. Frankly, it is impossible to segregate an A&E department in the way that you may think is appropriate.

The Chairperson:

If, on a Saturday night, drunk patients were to be segregated from non-drunk patients, there might be very few in the latter category.

Mr Compton:

That would possibly be true between 10.30 pm and 2.00 am.

Mrs McGill:

The incident, as it was relayed to me, was much more extreme than just involving one person. In fact, three or four PSNI officers attended, and they had to chase someone up the corridor. I was given the impression that the receptionist was the only person in charge; would that be the case?

Mr Compton:

No. I do not know the details of the case, but the fact that the PSNI was present appears to suggest that senior staff had taken the view that whoever was there was out of order and that a different arrangement was needed. On many occasions, the PSNI is called to accident and emergency departments, particularly at weekends, and none of the trusts will equivocate about that. If someone is being really abusive and difficult, they will be handled in that way.

Mrs McGill:

There should be somewhere else for those people. Everyone needs to be protected, not just people who are under the influence.

Mr Compton:

I understand your point.

Ms S Ramsey:

Thank you for your presentation. It is great to see you again, John. You and your colleagues have been around the Health Committee for a long time.

Do you see the board as being useful? I think that you are well aware of what needs to change, because you have been around for a long time. As Michelle suggested, the poacher has turned gamekeeper.

In answer to a previous question, you said that if an arena or environment were not up to standard you would refuse to put in the service, which, automatically, made me think that the only people who would suffer would be those in the local community. My question, therefore, is this: can you sack people or can you recommend to the Minister that they be sacked?

Mr Compton:

To clear up what I said about a service not going in; the board's obligation is to ensure that a population has access to a service. Sometimes, access to a service is confused with one that happens to be closest locally. No one will be denied access to a service. Where it is delivered from might be slightly different, but there is no denial of access to a service.

I think that talk about sacking someone is the wrong way to approach the issue. I think that you are asking whether there is a serious sanction for poor performance. I believe that there is. If the trusts were asked whether they felt that there has been a difference in accountability arrangements during the first nine months of the regional board, they would say yes. It has been very close — sometimes very, very close — as far as the trusts are concerned.

Clearly, the Minister asks the board for advice and opinions on the nature and shape of services, and he gets straightforward and honest answers. We were asked, for example, about the plans to close 150 hospital beds in Belfast. We were clear and unequivocal in saying that we did not believe that the services, as currently commissioned, could be delivered between now and the end of March 2010 without those 150 beds. We had no compunction in saying that. We went on to talk about the fact that that did not mean that services did not need to be reshaped in a more planned and orderly way, which might lead to bed reductions. We are quite clear, therefore, about what we will say as far as that is concerned.

Does the board have value? What can I say other than yes? My colleagues and I would not have come to the jobs if we did not believe that. From our point of view, the proof of the pudding will be in the eating. We are clear about how we should commission our services for the Province. There is a strong need for partnership between organisations, particularly, the political system and politicians, and the board, because it is quite clear that our current pattern and configuration of services is not fit for purpose for the future, and that means change. Sometimes, when we talk about change, that becomes equated to money. Change is much more equated to quality and outcome.

One of the things that the board is concerned about is not the process by which things get done, although we have an interest in that, but the outcome. For example, cancer survival rate figures were published last week. If people go to hospital for treatment or surgery, is their life expectancy what it should be, and how do we commission services to ensure that it is what it should be? If you want to go to an emergency department where you are seeing senior doctors and which is working 24/7, and you are not waiting, how should we configure that? If you want to allow people to remain at home, what are the implications for children, people with mental health problems and older people as to how those services are planned and delivered? That is what the board is about, and what we will want to be about.

Ms S Ramsey:

Thank you for your paper. It does not seem to mention the challenging of health inequalities, although it does say that one purpose of commissioning is to:

"reduce differences in access to good health and quality of life".

That is about investing for health, and needs to be across all areas.

Several weeks ago, the Belfast Trust told the Committee about the price of HIV drugs and other drugs. Is the board looking abroad, or are you in discussion with pharmaceutical companies, to try to get the best service for that? If so, where does that sit with the NICE guidelines with regard to healthcare versus finance? Iris will probably talk about the Billy Caldwell case, in which people had to go to other countries to get treatment. Further, does the board have a pass to carry out spot checks; and can we have a breakdown of the £3·8 billion?

Mr Compton:

We can certainly do that on a percentage basis across our programme-of-care range. There is no issue with that. We can probably leave that information with you today.

The answer to your question about pharmacy is yes: we take an interest in high-cost drugs and how they are afforded. It is a matter of negotiation with the pharmaceutical industry, and the relationship there is changing. Responsibility currently rests with the Department but is moving towards the board. We have very strong views on how that matter should be handled with respect to the purchase of generic drugs. One needs to discriminate between generic drugs — the common drugs that are used all the time and which can be purchased in bulk — and high-cost

drugs. We take a very strong interest in the issue because, clearly, we want to ensure best value for money for the population and for our ability to deliver services.

We have difficult decisions to take about drugs and their implementation, and about when, how and where drugs are used. We follow the NICE guidance in Northern Ireland, which refers to when not, as opposed to when, to use certain drugs, which is sometimes difficult to explain to individuals. This is easy to talk about in an academic context. It is not so easy to talk about it to a person who is sitting in front of us and who thinks that they may be entitled to a drug, and to whom we are indicating that the clinical experience means that it is not going to do them any good, that it will cost a lot of money, and that, therefore, we are not going to give it to them. We will always face that difficult interface with patients, but all that one can do in such a situation is to demonstrate that one handles it with integrity, straightforwardness and explanation.

As to whether I have a pass, the answer is yes, I can go anywhere. It usually takes about 30 seconds for the rest of the institution to know that I have arrived, but I and my staff do make visits. We head out a lot. We have made a huge effort to ensure that we are seen around the Province and in various locations. That is important. If we want to signal that we are commissioning, and that the board is working in a different way, we cannot operate a remote system; we have to be live and interactive with people on the ground.

You raised the matter of particularly difficult extra-contractual referrals, and we spend many millions of pounds per annum on those. That is done on the basis of clinical opinion, which is the key driver in decisions about what we are asked to do. I will put my colleague on the spot and ask how much we are spending this year on that.

Mr Mullen:

I can tell you how much over budget we are, although it is not an exact budget.

Mr Compton:

We are having to compensate that budget by some £6 million.

Mr Mullen:

We are £6 million over our allocation, in-year.

Mr Compton:

We have to make sure that we are using our wider budget in a way that allows us to do that. It relates to people with all sorts of issues, including liver transplants and particular interventions that are not easily, or cannot be, delivered in Northern Ireland. I am certainly not aware — and I would have expected it to have come to my attention — that we have refused anyone such extra-contractual referrals in the time that I have been in post.

Ms S Ramsey:

Are you sad that the GP negotiations broke down, based on additional money?

Mr Compton:

When discussions break down on the basis of money, it is unfortunate.

Ms S Ramsey:

It is a disgrace.

Mr Compton:

At the end of the day, we are trying to do the decent and right thing. I think that it is important that we work with our GP colleagues. They are an important building block for our services to be run and developed. However, it is always a matter of regret when what emerges is a rather difficult negotiation about whether a figure should be £5·20, £6·20, or £10·20. That is the wrong place to be.

Mrs D Kelly:

Thank you for your presentation. I have a couple of points. John, I can understand that you are trying to get the balance right, bearing in mind the RQIA report, but I was somewhat concerned to hear that it represented a snapshot on any given day, because the cumulative effect of that report is startling and worrying. I would like to say that up front.

On business continuity, your paper states that, as a consequence of voluntary redundancy and voluntary early retirement, the annual savings prediction is £5 million per annum, which is invested in service provision. In today's economic constraints, do we have a guarantee that that money will be reinvested in service provision? How is that determined?

Mr Compton:

There is an absolute guarantee that that is part of the money that goes into service provision. It then becomes part and parcel, if you like, with the £3·8 billion. It adds to that and gives us the opportunity to do things that we would not otherwise have been able to do, through the commissioning plan. If I gave the wrong impression with regard to the RQIA paper then that was not my intention. I was trying to point out that all of these matters must have balance.

Mrs D Kelly:

I appreciate that.

Mr Compton:

We would not, for one minute, accept that RQIA did anything other than provide a thorough, reasonable and balanced position as far as it was concerned. We have no difficulty with that at all.

Mrs D Kelly:

Those savings are, therefore, ring-fenced. I want to ask Fionnuala a question. The final sentence under the heading "Social Care and Children" states:

"However, there remain many challenges in this field not least support to frontline staff."

The McElhill incident is a case in point. As someone who worked in social services, I speak regularly to social workers. They feel undervalued and not supported by senior management throughout the trusts, which is due in some regards to multidisciplinary working. Social workers are not always managed by their own professional director, and that is felt particularly in children's services, where stresses are acute.

How can you make changes there? How can you ensure that staff are given some idea of expectations as regards case management? Under RPA, what steps are you taking to ensure that the community sector, particularly social services, gets its fair share of funding and resources vis-à-vis the acute sector? That has always been a challenge. If it is your job to ensure that the priorities of the Health Minister and Department are followed, what action are you taking to ensure that the Bamford review is implemented?

Ms McAndrew:

I will start with support to front line staff in children's services. Quite a lot of work has been going on in recent years across Northern Ireland — and I was leading some of that work — to bring in arrangements that were supportive of staff and make sure that social work in itself was more robust as it was delivered in children's services. Some of that was rehearsed by the trusts this morning, including a more robust assessment framework for children, policies and guidance to management on supervision of their staff, which includes case discussion and auditing, as well as quality-assurance standards, so that they can ensure that they are very familiar with the quality of work that is going on.

Other things have happened. Supervision arrangements are in place. Also, through the appointment of principal practitioners, who are advanced social-work practitioners, we have provided a mentoring system for front line staff and teams in children's services. Then, of course, there are always the in-service training arrangements and the post-qualifying framework. Those give social workers and front line staff opportunities to develop their skills and retain their competence and confidence.

Since the board was set up on 1 April 2009, we have commenced work on a children's services improvement programme. A number of work streams are aligned to that programme. We work closely with trusts. I must say that we have the trusts' full confidence and co-operation in that.

One work stream that we are looking at is to make sure that we have and develop robust information systems in the service. Another is to look at demand and capacity, because one of the challenges is the increase in referral rates over recent years and the demands that that puts on individuals and teams. Therefore, we are undertaking a piece of work to really drill down and understand what that means for front line practitioners as well as managers in the trusts. We are well on the way to collating information that will help us do that. That will also mean that board staff will go out into teams to talk to front line staff about their working arrangements, how they deal with referrals, and how case loads are managed. We are going to get quite hands on, in relation to understanding the challenges and what we need to do about those.

Mrs D Kelly:

I take it that the comments of staff will be non-attributable, so that staff can speak freely?

Ms McAndrew:

It is not about finding fault; it is to understand how we can improve things and how we can make a difference. It is in that context, and, as I said, we do have the full co-operation of the trusts to do that.

There is another work stream, which looks at management development. That relates specifically to your question. It makes sure that we improve and develop our middle managers in carrying out the task and the support that they provide to their staff. The final work stream, in which I am ably supported by my colleague, the director of finance, looks specifically at raising the profile of social work. In this environment it is important that we do that, and that alongside looking at lessons to be learned when things go wrong, we should look at the value of the practice and the good things that are happening within the social work profession, and at how we can reward and acknowledge social workers at the front line for the good work that they are doing. That is work that we are currently engaged in and it is proactive.

We will take some time to work through all the bits that we need to do to meet the challenges, but we are pleased to report that it is under way.

Mr Compton:

To respond to the two other points: we have a Bamford task force, which has the Public Health Agency closely integrated into it, and that is about the implementation of the Bamford policy. It is expected to report directly to the Minister on the various things with regard to that. All of that is taken seriously.

As to the money and the percentages, it is worth noting that somewhere between 55% and 60% of the money we spend is spent on community services. You might not think that, sometimes, from reading the 'Belfast Telegraph' or other journals, because they focus on hospitals; but in fact we spend more money on community services than in hospitals.

Mrs D Kelly:

Do you treat more people in the community?

Mr Compton:

Absolutely: it is an important issue. Sometimes, the view is that the ratio is 90:10 the other way round.

The Chairperson:

Some Committees have pregnant pauses in which the Chairperson has to try to squeeze questions out of the members, and then there is the Health Committee. *[Laughter.]*

Other than putting witnesses under a light bulb and slapping them around the cheeks, I do not know how members could be any rougher. We continue.

Mr Gardiner:

I am not going to embarrass you. Do you agree that the Health Minister has raised the bar with respect to health care in Northern Ireland?

Mrs I Robinson:

Go on, say no.

Mr Compton:

I think the bar has been raised. If one looks at performance — and this is not a political statement — then the standard of healthcare has improved. The objective information speaks for itself.

The other side of that is that we have rising demand. Last year, we had 12% rising demand; this year we have 9% rising demand. It is extremely difficult to balance the two things at one point in time. Demand is undoubtedly an issue. We are spending a lot of time trying to understand the demand, because the nub is to understand it well. Therefore, the work that Fionnuala has indicated on family and childcare will help us understand demand capacity. The work we are kicking off with general practitioners, about understanding referral patterns and referral-rate patterns — because they are quite differential — will also help. One doctor may refer 40% of the patients he sees and another may refer 20%, but one cannot say that either is good or bad. However, we need to understand what is generating that pattern. If we do not get a sense of demand and what is generating that demand, then no matter how we lift our ability to do things in certain areas, we will always find ourselves dragged backwards because that demand will act like a bungee rope on our backs.

Mr Gardiner:

What action do you take with those who are not making the target?

Mr Compton

As I said to you before, we are currently in discussion with one organisation as to whether we should shift some business from it as a consequence of difficulties that it is having with the target.

Mr Gardiner:

Is that in order to get better results?

Mr Compton:

Yes. We are not interested in the organisation; we are interested in what care patients and people get. If that means that, on occasions, we have to shift some work from area A to area B — as long as accessibility to area B does not cause any overt distress to a population — we will do that.

Mr Gardiner:

Are there many organisations in that category?

Mr Compton:

At the moment, we are talking to one organisation about a particular set of circumstances.

Mr Gardiner:

There is only one organisation at the moment, then?

Mr Compton:

We are working on individual pieces of work with organisations and primary care providers. However, that has gone to a slightly different position.

Mr Gardiner:

Well, speed it up.

Mrs I Robinson:

I am definitely going to buy Samuel a pair of pompoms.

Mr Gardiner:

I do not require them.

Mrs I Robinson:

His cheerleading is rather embarrassing sometimes.

Mr Gardiner:

It is great to have —

Mrs I Robinson:

I am speaking.

The Chairperson:

Through the Chair, please. If you are going to insult each other, do it through the Chair.

Mrs I Robinson:

When one talks about the Minister raising the bar, I find it so unbelievable that anyone could make that statement, although I give him 100% for trying.

Mr Gardiner:

He agreed with me.

Mrs I Robinson:

Well, he would, would he not? That is why I am going to ask the board about how independent it is when it comes to criticising what goes on in the trusts and in the Department as a whole. We all know that board's budget comes from the Department, and I sometimes question the independence of that set-up.

We have heard about the Minister raising the bar. However, you have heard the points that members made today. The glaring and ludicrous cost of taxis has been raised today, and Alex made a good point: he suggested purchasing a couple of vehicles and hiring a couple of drivers in order to cut down considerably on the £4 million spent on taxis across the trusts. I would like to hear what the board is going to do about that.

One of yesterday's papers — I do not whether you read it — said that people in Northern Ireland are less likely to improve after suffering a stroke or from having a heart condition or cancer than people in other European countries, even though some of the most recent countries to join the EU are very poor. Our results for people who have had strokes or certain types of cancers were not good. In fact, they were very poor by comparison.

I would also like to hear your views on the lack of prescribing of the drug for people suffering from Alzheimer's disease? I know that the NICE report indicated that certain drugs should not be prescribed to Alzheimer's sufferers. However, someone raised the point earlier, and I had a note to raise it, about the amazing turnaround by a minister who was given the drug. When one thinks of the £4 million that was spent on taxis, how much money could be saved and could be used to purchase drugs for Alzheimer's sufferers?

Lastly, what is going to be done about theatre usage? In other countries, there is 24-hour usage, and hospitals use rotas to ensure maximum use of theatre time. We must get out of the mentality of thinking that everything closes down at a certain time and that operations should not go on through the night. That is a very important area for the board to look at, and if it has not looked at that, I hope that it does so. I think that doctors or consultants who come over from England should be working at night to help reduce the waiting lists. That would be a more effective way of working.

Mr Compton:

I have noted down your questions to ensure that I answer them. You asked whether we are independent. We work in a system that you clearly understand. Will we say what we think? Yes, we will. It is as simple as that, and we do that.

The Chairperson:

Are you allowed to say publicly what you think?

Mr Compton:

Yes. The board holds a public meeting once a month, and if an issue is raised, the board will make its views known on that.

For example, every month we show the performance reports for every organisation and indicate, in public, how each organisation is performing. We do that, and we do not have any difficulty in doing that. We do not edit that information for public consumption; we say it as it is. We work inside a system, as that is the responsible way to do it. However, we are honest and straightforward about what we say.

The Chairperson:

Why are the minutes available up until only September on the website?

Mr Compton:

That may be to do with the website: it is not to do with the fact that the minutes are not live. The minutes from October and November are available. Indeed, anybody who comes to a board meeting will get the minutes from the previous meeting. There is no issue around that. The issue with the website may be administrative or technical.

The issue around taxis makes for an interesting debate, and I will make a couple of observations. The first thing to understand is what the taxis do. When one says "taxis", that immediately creates an image in people's heads. A lot of spend is on taxi fares for children or on childcare arrangements. That has to do with children who are placed, for example, in a foster home that is perhaps some distance from their school. The children will be taken to school and back every day during that arrangement. It has to be done using a taxi: it could not be done through a bus arrangement as that would be much too difficult to organise. Using a taxi is much more efficient than trying to develop a transport department. There is a lot of emergency travel, and trying to organise things on a 24/7 basis would require a huge fleet of vehicles and a huge number of people in full-time employment.

There could well be efficiencies to be made. No one is disputing that the arrangements should be looked at. However, this information needs to be rooted in factual discussion and debate around how much travel is not required or how much of it is inefficient. I suspect that much of the arrangement is quite an efficient, pragmatic and sensible way to deal with the problem that one is faced with. Certainly, we are interested in costs in that regard.

Theatre usage is also an interesting issue. You are absolutely right about the nine-to-five, 24-

hour situation. The issue is around what we, as a society in Northern Ireland, want from our healthcare system. If we wish to configure our system in the way that it is currently configured, then it will be very difficult for us to run that system on a 24-hour basis, with 24-hour use of theatres, because of the number of locations involved. This is not about money. If we set the issue of money to one side and assume that we have all the money in the world, we still could not employ the staff: they would not come to work in an area because there is not enough activity in that area. Therefore, one has to realign how it is done.

It is important that when people use theatres they do so with senior staff. A lot of the Confidential Enquiry into Perioperative Deaths (CEPOD) recommendations, and those about theatre use, clearly show that if theatres are not being properly used, with senior staff, then, by and large, outcomes will be not as good as they would have been otherwise. We need to think about how to configure our services to get to the point at which we can do that. In the meantime, we need to separate emergency and elective theatres. That is the big issue. We need to be running emergency theatres all the time, probably in a relatively small number of centres, and have a large number of elective centres that are running very efficiently. All that will mean a lot of change and a lot of reconfiguration, and we all know what the issues are when we start to talk about those things. We all know that everybody's first reaction is that it is a debate about money. It has nothing to do with money. It is about quality and outcomes. As a board, we will be articulating that, and, as time goes on, how to handle those sorts of things.

We touched on the NICE guidance on drugs. As an organisation, it is impossible for us to know, even with our colleagues in the Public Health Agency who work very closely with us, the appropriate thing to do in every occasion for every drug. That is what NICE is about. When NICE gives us a recommendation on how a drug should be used, it does so after a lot of validation.

Mrs I Robinson:

Those recommendations are sometimes based on costs.

Mr Compton:

Yes, recommendations are based on cost too, but one cannot divorce the arguments of cost, quality and performance. We refer to it as the "iron triangle".

Mrs I Robinson:

Is it not cheaper in the long run to give a patient the right drug? That way he or she will not present to his or her GP all the time?

Mr Compton:

I am genuinely not aware of situations in which we refuse to give people medication on the grounds of cost.

Mrs I Robinson:

That is not what I am hearing.

Mr Compton:

I am genuinely not aware of any such situations. If there is information contrary to that, I would be grateful for it. That has not been my experience, and I can only relate my experiences to you. There will be some controversial decisions about drugs and when to use them.

Mrs I Robinson:

The arthritis drug, for example.

Mr Compton:

Yes, there will be controversial decisions. However, the only safe way to make decisions is to base them on evidence. If a decision is not based on evidence, the argument becomes emotive, financial and one that is, frankly, unwinnable. The argument in support of a decision is only winnable on the basis of evidence, and that is how we decide on the use of drugs. That is why we use the NICE guidance.

There is always a multitude of reports saying that standards are sometimes good and sometimes bad. I do not know the particular report that you referred to, so I speak with that sense of absence. If you look at our cancer registry, for example, there are year-on-year improvements in the outcomes for cancer patients in Northern Ireland. Our management of cardiology, and the way we deal with people who have had heart attacks has changed dramatically over a 20-year period. There has been a huge emphasis on health-improvement, lifestyle and information agendas, which has considerably improved the outcomes for patients.

There is always progress to be made, and there are always challenges to face. We have to compare our situation with other First World, Western countries, because that is the peer group with which we want to compare ourselves. If that comparison highlights big deficits for us, we will have to pay attention to them. I will look specifically at the report that was mentioned.

The Chairperson:

Mr Compton, after that marathon session, I feel like asking you whether you would take the job if it was offered to you, because it seemed like we were conducting a job interview. Thank you for answering a huge number of questions so expertly. There are still a few questions that we did not get round to asking, which we will send to you, but you managed to deal with a lot of the issues on our minds. Our questions have spanned every aspect of the Health Service and of social care. I am sure that this meeting is the start of an ongoing relationship between the board and the Committee. Our thanks again to you and your team — I think that Mr Cummings is a bit annoyed that he did not get to answer that often, but apart from that everybody else is happy.

Mr Cummings:

I do not mind. *[Laughter.]*

The Chairperson:

Thank you very much.