



Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

**Departmental Response to the ‘General
Report on the Health and Social Care
Sector in Northern Ireland — 2008’**

14 January 2010

NORTHERN IRELAND ASSEMBLY

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HEALTH, SOCIAL SERVICES
AND PUBLIC SAFETY**

Departmental Response to the ‘General Report on the Health and
Social Care Sector in Northern Ireland — 2008’

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Members present for all or part of the proceedings:

Mr Jim Wells (Chairperson)
Mrs Michelle O’Neill (Deputy Chairperson)
Mr Alex Easton
Mrs Dolores Kelly
Mr John McCallister
Mrs Claire McGill

Witnesses:

Mr John Cole)
Mr Sean Donaghy) Department of Health, Social Services and Public Safety
Dr Andrew McCormick)
Mr Dean Sullivan)

The Chairperson (Mr Wells):

Today’s evidence session on the ‘General Report on the Health and Social Care Sector in Northern Ireland — 2008’ is concerned only with section two, which deals with performance. The witnesses will return to deal with other aspects of the report. I welcome Dr Andrew McCormick, who is well known to us as the permanent secretary of the Department of Health, Social Services and Public Safety (DHSSPS), Mr Sean Donaghy, the deputy secretary in resources and performance management, Mr Dean Sullivan, the director of planning and performance management, and Mr John Cole, who briefed the Committee recently. He is a

deputy secretary, chief estates officer and sustainability champion. He is similar to Peter Mandelson in that he has many titles. You are very welcome. You are experienced hands and know the format. You should make a presentation of about 10 minutes, after which members will ask questions.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):

It is good to be here again. I am happy to answer questions about and discuss the report on the Department's position, as seen by the Audit Office, for 2007-08. It is important to highlight and draw attention to the fact that this is a new process of scrutiny.

The report has been prepared annually for a long time, and, given the nature of how the Public Accounts Committee at Westminster handled matters under direct rule, there was never time to examine it. The Public Accounts Committee at Stormont has also decided to work through the report and allow this Committee to play a role. That is an important development in the level of accountability to which we are all subject and committed. We recognise that that is our obligation as officials, and it is part of the role that we accept entirely.

We are willing and open to accept the Committee's approach and to examine the material and the Audit Office's scrutiny of the Department and the entire health and social care system. We are pleased to have the opportunity to respond to the Committee's point of view on the matter. I hope to discuss some interesting and important topics, because we are here to manage the performance of the system. It is an essential part of the role. Fundamentally, the Department has direct responsibility for policy and strategy. However, all responsibility for the delivery of health and social care under the legislation is vested in the Department, which fulfils that role by delegating responsibilities to a range of organisations.

It is important to note that 2007-08 was the first year of the operation of the five large trusts. The reorganisation took effect on 1 April 2007 during that part of the review of public administration (RPA). Therefore, the report covers the first year of the trusts' operation. Some issues that arise from that reflect the transition from the former 18 trusts, some of which covered acute services only, some of which covered community services only and some of which covered both services. The 18 trusts merged into five integrated trusts in April 2007, and several issues have arisen about financial management, financial performance and operational performance. That is an important context.

Issues have moved on since then, and we are happy to consider the progress with the Committee. There will be an annual report for 2008-09 in due course; it is being prepared as we speak, and the cycle will continue. The material in section two focuses on the financial performance and sets the yardstick of break-even in the context of the way that has worked out in previous years. The track record of securing financial control and delivering on the financial objectives has been strong. The tightrope that we ask all the organisations to walk is to ensure that they never overspend. There is a statutory obligation to break even, which is defined in the report; however, in practical terms, we apply a tighter expectation of organisations to break even. The interpretation we apply and hold organisations to is that they should be no more than 0.1 % above their set limit, whereas the statutory obligation is slightly wider than that.

One side of the coin is an absolute obligation not to overspend and to break even, but the other side is to ensure that there is very limited underspend. We expect the system to secure a good outcome on those issues, and the Health Service has done well on that over a number of years. We have never had a major scale of underspend, despite the fact that it is a highly complex system, with many organisations that all have different roles to play, and a range of different budgets of different natures, some of which are subject to variation quite late in the financial year.

For example, a close eye must always be kept on the prescribing budget. If there are particularly bad issues in a winter period, that can raise the rate of prescribing more than has been expected and can threaten budgetary control. That is a demand-determined aspect of our services, which all the organisations need to monitor carefully. That is one illustration of the range of budgets that is being managed to secure control, adherence to the limits set by the Assembly and delivery of the activity and services to the public that we are expected to produce, and to ensure that we are fulfilling the obligations on the system. There is a good track record of performance not only for 2007-08 but over the years before and since then. That is part of what we do.

We can discuss where you want to go about scrutiny, but we had a lengthy session with the Public Accounts Committee on operational performance in the autumn, and there is a range of different issues relating to that. We need to secure further progress on the public health agenda, the indicators for which are measured on a more long-term basis. They are not expected to change radically from year to year, but we have to sustain consistent, secure progress on that range of indicators. We are glad to see continued improvements on issues such as life expectancy

for the community as a whole, but we are conscious of the issues in relation to inequalities, which are, of course, more difficult.

On the service performance side, 2007-08 was one of the years in which we made progress on a range of service targets and objectives to secure improvement in the performance of the system across the range, from acute services to community and social services. At that time, the emphasis was on the first main year of targeting in relation to unscheduled care: that is, trying to ensure that accident and emergency units are delivering to good standards. There were also targets in relation to a number of other indicators, including elective care; I can discuss that if you wish.

In John's territory, there is a section to cover on the capital programme, the future challenges that face us and the issues that have been secured. There is a good track record of delivering projects on time and on budget. Those are the topics covered in broad terms. I am happy to leave it there and take the discussion where you wish it to go with your questions.

The Chairperson:

My reading of the present situation is that the trusts are allowed a variation of 0.5%, with one exception. On the mainland, the National Health Service (NHS) trusts can carry over deficits into the next financial year for a maximum of three years in order to create a degree of flexibility. Some of the trusts said that it would make good economic sense if they were able to borrow from one year in order to accumulate savings in the following year. Major projects that the trusts run often do not fall neatly into a standard financial year. Why have the five trusts and the Northern Ireland Ambulance Service Trust not been given that level of flexibility?

Dr McCormick:

It is important to put that into the context of the English practice. It emphasises, as much if not more, the concept of carrying forward underspend into the following year, which is rather more benign and which leaves us with less risk of a regional overspend. Since around 2000-01, we have expected trusts to break even each year. As has been explained, a tighter regime applies here than applies across the water, and the reasons for that are important. It is to do with securing strong financial control. The concept of projects having a varied pattern of spend from year to year applies more strongly on the capital side than on the recurrent side.

The emphasis of most of what I am saying is on recurrent expenditure. That is because the largest recurrent expenditure, by far, for the trusts is salary costs, which are relatively stable and predictable. If the pattern were as you described, I would be concerned about how the trusts could adjust materially from having a high staffing level one year to a low level the following year and hence achieve not only a steady level of spend but a high spend one year that is offset by the break-even duty, taking one year with another, which is a statutory obligation. That would require more significant adjustments in staffing levels than we are comfortable with.

We want to secure strong financial control across all organisations. The Department has to break even. That is an absolute requirement under our accountability to the Assembly, and it is important that we manage that.

The Chairperson:

However, you reckon that trusts in England can be trusted to carry underspend and overspend, if they so wish, but that our trusts cannot be trusted to do that.

Mr Sean Donaghy (Department of Health, Social Services and Public Safety):

In England, a new category of organisation — foundations trusts — was invented. The Department of Health and the English Treasury had a significant debate about whether that was a good or bad idea. The effect is to take foundation trusts' books of account off the face of the public expenditure account so that it is possible for the trusts to accrue significant surpluses and deficits but for that not to affect the position on overall health spending as is reported to Westminster, thereby not constituting an Excess Vote. That has not happened in Northern Ireland. Therefore, if a trust overspends, the DHSSPS overspends, and the Executive would rightly and properly say that that the Department has failed in its duty to have good custody of the funds that were allocated to it.

The Chairperson:

Therefore, a different structure is in place in England. The report does not deal with 2008-09. How have things panned out during that year, and what is the latest prognosis for the current financial year?

Dr McCormick:

The financial year 2008-09 was more difficult than 2007-08. That was the first signal of a

problem across the service. Technically, the Northern Health and Social Care Trust broke even within the statutory limits. That was acceptable, but it was a sign that there was some more pressure in that trust and also in some other trusts. There were signs of more difficulty, but control was still achieved. Of course, we now need to ensure that we retain control in 2009-2010.

In the first part of this year, it was necessary to examine carefully the emerging issues across all the trusts. For example, uncertainty arose from costs to combat swine flu. We had much work to do to consider the range of complex issues throughout the autumn, which led us to recognise that there were some issues in the Northern Trust and the Belfast Trust on which the cure would be worse than the disease. If those trusts had taken the corrective action necessary for them to work within preset budgets, there would have been damage to front-line services. We had to make allowances for that.

That is not to say that we accept higher spending levels than we want to. We have to ensure that we adhere to the budgets, but we have found a way to manage the system effectively by holding back other expenditure to ensure that there is an amount held by the Department that can offset the amounts presently required by the Northern Trust and the Belfast Trust. That is the way in which we have had to do it. It is not the first or the best way to do it; it is an appropriate response to an emerging and quite difficult situation.

The root cause of that situation is a combination of the fact that the rate of growth in spending has not matched demand and that we have had some difficulties in delivering the efficiencies that were required after the comprehensive spending review in 2007. The first 3% of efficiency savings had to come out in 2008-09, which was achieved across all the organisations with difficulty. A further 3% was required in the second year, 2009-2010, which was a bit more difficult. It was difficult to make those savings on a recurrent and stable basis and make the necessary adjustments to the pattern of services. That was challenging and continues to be so. We can only speculate on how difficult next year will be.

The Chairperson:

I want to ask you later about the legacy trust deficits, or non-deficits. We are having great difficulty in understanding some of the material that you sent to us on that issue.

Dr McCormick:

That is fine.

Mrs O'Neill:

I want to ask about the break-even duty. We received reports during the year that trusts are in severe danger of not being able to meet the break-even duty. For example, the Belfast Trust was predicted to have a deficit of around £36 million. I note in the report that the Department informed the Audit Office that:

“it closely monitors the financial position of all HSC organisations on an ongoing basis and requires individual organisations to take corrective action where necessary”.

It seems really strange that all the trusts that were predicted to have such big deficits were able to come within tolerable limits of the break-even duty. I cannot understand that. Will you give me some more information on that? There seems to be more to the issue. How much non-recurrent funding are trusts receiving each year on top of their allocations? The situation seems to be very unclear, and I am unable to get my head around it.

Dr McCormick:

It is complex territory, and I am sure that Sean will be able to add to what I say in my response.

There are several important issues. Projections are made early in a financial year, which are based on what is emerging as the actual pattern of spend. Every organisation will look at what was spent in month 1, month 2, month 3, and so on. When they are projecting forward from the first few months of the financial year, the prediction on where they will finish in month 12 is subject to a range of uncertainty. The organisations have to make an allowance to ensure that they achieve the break-even duty by month 12. They will examine the actual pattern of salary costs, and so on, on which there will be uncertainty.

Changes and interventions will be made as the year goes on in order to, for example, deliver the efficiency savings that are part of their plans to reduce spending. Some of those efficiency savings do not take effect until month 4, month 5 or month 6. The pattern of spend changes as the year goes on, and, therefore, the projections change. One factor is moving from less knowledge at the start of the year to fuller knowledge as the year goes on. It is inevitable that that is how things work out. That is one aspect.

There is also the non-recurrent point about our process of managing services to ensure that we get the optimum outcome in relation to the best use of money. That is designed to have a degree of tension in it. The financial year 2008-09 was the last year of the old commissioning system with the four health and social services boards. They deliberately held back money to be sure that they got what they commissioned. They deliberately and consciously said that they would confirm the release of money to trusts only if they were sure that they would get what they asked for. That is a manifestation of their trying to do a job in the public interest to get the best possible combination of the spending of money and the delivery of outcomes — at least of activities — to secure the best possible spend.

In 2007-08 and 2008-09, the pattern was that substantial money was held back to hold trusts to account in that sense. It ensured that they delivered what the commissioners asked them to. That is another reason for a level of uncertainty. I say that because the situation is changing, and that is not the only way in which things can be done. I am explaining what happened historically. It meant that there was a range of uncertainties.

Another dynamic is that people want to make a case for their activities and, therefore, will argue for and pursue resources. That is an entirely legitimate and proper part of the process, but it means that there has to be scrutiny and challenge. No finance director accepts what everybody says at face value. The finance directors, and, hence, the Department, take a judgement about what is necessary to achieve the right balance of objectives. We do not simply try to solve one dimension of the issue, which is to achieve financial balance; we also seek to secure the best distribution of resources and the best outcomes. It is a complex picture, and issues change.

In the current financial year, an important event occurred: as the year went on, the amount that was required for the employer superannuation contribution changed, which made a difference to what we needed to spend. Events can work up or down. There is the uncertainty of projecting the budgets, which are enormous. For an organisation with a budget of £1 billion, such as the Belfast Health and Social Care Trust, it is intellectually challenging to be precise about what will be spent in month 12 during month 1. It is a challenging task because there is uncertainty in projecting. There was the deliberate holding back of resources by the boards to try to secure a better outcome; it is a complex world; and numbers change for external reasons. Those three factors, at least, mean that the situation is complex.

Mr Donaghy:

Andrew has covered the issue well. A deficit of £36 million was mentioned. Very often, the figure that is put forward by trusts will portray the challenge to its fullest extent. The report states that the trusts had plans in place to deliver efficiency savings of £18 million, which means that the £36 million becomes £18 million as soon as one reads the next sentence. We tend to find that trusts take a prudent approach; they say that they think that they may have difficulties at a certain level in the year ahead. There is a tension between getting best value for money for each pound of taxpayers' money that is spent, getting the maximum possible performance from that and ensuring a break-even position.

Given all that, the fact that there were four boards in 2007-08 meant that, at times, the approach to managing that tension was not as consistent as we would have desired. That was one of the motivations behind collapsing the four boards into one. We expect that that will facilitate us in having less difference between the starting position and the closing position. Less uncertainty will be attached to how funds will flow because there is one set of designs behind that rather than four. That is one of the improvements that is associated with the RPA process.

Mrs O'Neill:

In order to help us to understand that properly, will you also provide a breakdown of all non-recurrent funding to the trusts and when they received it during the 2007-08 financial year?

Mr Donaghy:

The Department did not maintain those records for 2007-08. They allocated that task to each of the four boards. It was part of their job to manage the tension between the funds that they had available and the level of service that each trust, independent practitioner and the entire range of bodies were able to provide. Therefore, I could not undertake to provide that information from departmental records. However, we will certainly check whether the four boards' records will support that. They should have some of that information. I am conscious that I would be asking a new organisation to go back into and interpret the records of four older organisations. However, it should be possible to provide some of the picture to the Committee.

Dr McCormick:

We will do our best.

Mrs O'Neill:

Thank you. The report clearly states that improvements have been made in operational performance, and so on. It suggests that improvements in public health fell short of initial expectations. There are key questions around Investing for Health. However, we will not get into that today.

With the reliance on the use of the private sector for additional capacity, the decision this year by the Belfast Trust to suspend all of that activity and then the Minister's announcement that it would go ahead, is the Department focusing on short-term gains through using the private sector and not thinking long term? It will be pretty difficult to sustain that. You may meet your target this year, but can you do that again in a few years' time? I have concerns about that.

Dr McCormick:

We are clear that, in looking ahead, the right thing to do is to secure a better balance between the publicly funded system's capacity — that of the trusts — and its ability to meet the level of demand. Our absolute objective is to achieve that equilibrium. If they were fully balanced, there would be no need to use the independent sector.

With regard to 2006-07 and 2007-08, we certainly took the view that one of our main objectives during that period was to try to deal with a long-term problem on long waiting times, which, by definition, is a backlog. It would not have been appropriate to invest in permanent capacity in the health and social care system locally given the assumption that the level of activity that was needed to clear the backlog would be greater than the stable long-term requirement. Therefore, we have a strong conviction that the right thing to do was to clear the backlog. It was the right thing to do for both the short term and the long term.

This year is the first year for some time when the Minister has not set more demanding elective care targets than those of the previous year. He set targets of nine weeks for outpatients, nine weeks for diagnostics and 13 weeks for inpatient procedures. Those targets were to be achieved by April 2009 and to be sustained throughout 2009-2010. This year is also the first year for some time that there has been no target for an additional decrease in waiting times. That suggests that we are approaching a state at which we are in balance and have achieved a steady flow rather than having a steady flow plus a backlog to be cleared.

As it has turned out, it has exposed issues with internal capacity. Therefore, the Minister is releasing £25 million for next year to invest in certain specialties, bring them into balance and thereby reduce our dependency on the independent sector. That is the clear determination that we seek to achieve. I doubt that we can ever eliminate the need completely. There will always be issues about small specialties and highly specialist activity, and also a need to ensure that there is a test and a requirement on performance and that people actually deliver to objectives.

Mr Dean Sullivan (Department of Health, Social Services and Public Safety):

That is a fair summary, Andrew. During the past three years, we have needed to use the independent sector substantially. However, we have used it wisely and have secured substantial reductions in patients' waiting times.

It was a short-term fix. The alternative was for us to spend years putting in place the additional capacity, and it would have taken years to put in place the scale of additional capacity that would have been required. Meanwhile, patients would have had to wait for years for treatment, because that was how long patients had been waiting in 2005-06. The Department did not think that that was acceptable, and it was prepared to use the independent sector. Equally, as Andrew said, to invest recurrent capacity at the level required to reduce the backlog could have resulted in us ending up with significant overcapacity, compared with that required to maintain equilibrium. This has been the first year of stability. There has been a substantial increase in demand: 12% in 2008-09 and a further 9% in 2009-2010.

The Chairperson:

We have heard that figure.

Mr Sullivan:

Those are significant increases, which have resulted in tens of thousands of additional patients being seen in outpatients and thousands of additional inpatient and day-case procedures. They are not small changes.

This year, as Andrew said, we have plans to work with commissioners to invest £25 million that will "close off" — to use an internal terminology — a number of specialties and bring in specialties to balance. However, that will not do it all. We had plans to make a similar level of investment next year, but that will need to be considered in the light of next year's financial

position. Nevertheless, the Department's goal is to get to a place where we are in balance. There will always be a need to use the independent sector from time to time. However, we would like to get to a place where that is on a spot-purchase basis in response to particular short-term pressures, rather than being the only way in which we can maintain some sort of balance in the specialties.

Mr Easton:

I will be straight from the start and say that I am no expert on monetary matters. What is the money called that is held back from the trusts? How is it held within the budget? Is it in a special account? Why do you not simply give it to the trusts upfront, the logic being that you would not have a panic three months before the end of the year if someone were to brief the press and say that there was not enough money and that services, beds and nursing jobs will have to be cut, while the money is, to an extent, held back centrally with the Department? Why is the money held back and not given straight upfront, which would avoid some of the drama?

My next question relates to the management costs that are mentioned at paragraph 2.2.7 of section two of the report. All the trusts are within the 5% ceiling, except for the Ambulance Service Trust. Is there any evidence to show that those management costs will increase over the next and subsequent years?

Dr McCormick:

With regard to the issue of holding money back, I assumed that, on the previous line of questioning, I would get the chance to go on to say that the new Health and Social Care Board has changed the approach significantly: it came in with the determination to release as much of the resources allocated as possible. The Department allocates money to commissioners, and they then draw up agreements with trusts as to what services will be delivered.

The four former boards, given the variety of practices that Sean explained, had different ways of doing things, which was part of what they were there to do. The new Health and Social Care Board took a regional approach and made an early decision that it would release as much as possible of the resources early in the year. In 2009-2010, the whole system is adjusting to a different behaviour of no longer holding money back.

To answer your question: people thought about the subject, decided that there were issues and

wondered whether they were getting the best possible total outcome. They decided to release more money earlier. It was never a case of the Department holding money back. Primarily, it was the commissioners and the old regime saying that that was how it was done and that was how they would keep some tension in the system. The new board decided that it would release as much as possible upfront. The corollary of that is that, given that the trusts no longer expect the budget to change as the year goes on, it becomes their responsibility to plan and manage on a more fixed and certain basis.

What is happening in the current year is affected by the fact that it is the first year of doing it that way. The change of system has had some frictional effect, which means that it has been difficult for people to handle. There were also major external events, such as swine flu, which meant that the management of the system was thrown into some turbulence, especially through the summer and early autumn, but, fortunately, less so now. There were also other changes, which were coupled with the overall difficulty of delivering efficiency savings. That is why things have changed. We accept your point that the reasons for holding money back were not as strong as they should have been, and people are changing their behaviour. Perhaps Sean will add a reply to that first question, and I will come to the issue of management costs in a moment.

Mr Donaghy:

There has been an evolution of the practice, as referenced in the answer to Mrs O'Neill's earlier question, in that the view is now that one commissioner is better able to predict the financial flows rather than four views being taken, leading to the earlier release of funds. With regard to the notion of drama in the course of a year, this year is distinguished from previous years. There has indeed been some drama this year because there has been some genuine financial uncertainty, for a variety of reasons. There were unexpected issues, such as the need to manage swine flu, the scale of demand increases, as my colleague Dean referred to earlier, and the real difficulty facing the Northern Ireland block. The difficulty in achieving certainty on how those costs were to be met produced additional uncertainty and drama this year.

However, in each of the years, from roughly 2001-02, despite improving performance and significant tension and challenge to the financial management agenda, the service has broken even from year to year, with relatively little drama on issues surrounding financial management performance.

Dr McCormick:

In answer to your question on management costs, an increase is not expected. The service has adjusted to the significant changes made through reorganisation, which meant a substantial reduction began to take effect from April 2007, when the trusts merged. That process was the main stage of reorganisation; it finished in April 2009 with the creation of the new Health and Social Care Board, the Public Health Agency and the closing of several organisations.

There is more to be done on shared services. That is the remaining dimension of delivering reorganisation, and there are some further savings to be secured by that major project, although it has its own challenges. We are clear that there is tight control on management costs. We have achieved the main objectives of change in that regard. The Minister confirmed and has reinforced the need to deliver the level of savings committed to in the initial RPA plan, which was £53 million per year recurrent to be completed by April 2011, and for that to involve 1,700 fewer posts in management and administration across the health and social care system. That is on track to be achieved. The main changes have been secured, and we have a much leaner, tighter management structure than previously.

When the RPA began at the start of the millennium, the question was: how could the health and social care system be reorganised to secure leaner and more fit-for-purpose management arrangements for the region? That was adopted and confirmed by successive Ministers.

Mr Donaghy:

I will make a brief comment in the interests of clarity for the Committee. The average management costs for trusts over the period of the report — 2007-08 — were 3.87%. We think that that is a strong performance. That includes the full costs of the trusts, boards, chief executives, directors of the trust, the total finance function, the total human resources function and most of the information function. That is a huge range of staff, and it compares strongly with what the private sector generally invests in management as a whole.

If the 2007-08 figure is compared with 2008-09, 3.87% becomes 3.94%, so there was a small percentage increase. Below that, there are fewer people who are classed as management and administration. We attest to that by counting the heads. The reason for the percentage increase is due to the impact that Agenda for Change has had on salaries and the costs that are associated with each individual. It is also because of a national recommendation that employers' pension

contributions should increase from 7% to 16%. Each individual costs a little more, but there are fewer of them. The reason why each individual costs a little more is because of national pay awards and recommendations on the appropriate level of pension contributions by employers.

We are confident that the costs are going down. The first period in which the boards shrank from four to one is 2009-2010, so the further reduction that is associated with those management costs is not yet available to us. It was a full year in advance of those changes. Andrew mentioned shared services, through which we will rationalise finance, human resources, procurement and a range of other office functions in order to reduce costs and improve efficiency.

The Chairperson:

I want to return to the issue of legacy debts. Some of your staff, rather than attend their Christmas party on 21 December 2009, beavered away and tried to answer the question that has bedevilled the Committee about whether debts were incurred by the new trusts that were legacy debts from the old 18-trust system. You wrote to us on 21 December 2009 in response to us taking evidence from the trusts. Each of them said quite clearly that one of the problems with meeting their targets was the fact that they had inherited debt, whether it was from the Sperrin Lakeland Trust, Down Lisburn Trust or whatever.

The Minister wrote to us on 21 December 2009 and said that, on 1 April 2007, the trusts were free from any alleged debts. How can it be that the trusts tell us that they were tied down with the anchor of inherited debts, and you say that they did not exist? I suspect that the trusts may have noticed if they did not exist. We have written to you and to the trusts because we do not understand where that response is coming from. Obviously, it is relevant to performance. Who is right?

Dr McCormick:

There is a special case. The one exception that we need to explain fully is —

The Chairperson:

The Sperrin Lakeland Trust?

Dr McCormick:

That is right. A deficit was discovered after the year end in 2007, which was quite a tricky

situation to handle. However, the Western Health and Social Care Trust, to its credit, recovered the ground in its first year of operations. That was a significant achievement in a difficult new context.

The issue links to the discussion that we had about non-recurrent allocations of money. The recurrent financial position is best assessed by examining the ongoing cost of activities that are being provided, such as the payroll and all the associated costs. If that is considered recurrently, there could be a problem, but the technical absence of any debt is ensured. The Minister, of course, is right: there was no debt at that point because the trusts had received sufficient non-recurrent money to offset the underlying gap between their payroll costs, as it were, and their recurrent budget. It is a matter of separating the recurrent and the non-recurrent. That is vital to getting at that piece of information.

Mr Donaghy:

If it is helpful, I will seek to draw an analogy. Andrew is right: there was no debt. When the 18 trusts wound up on 31 March 2007, no amount of money was owed by one party to another, with the exception of the Sperrin Lakeland Trust. Each trust began with a zero balance — a clean sheet. Did someone owe money to someone else? Was there an amount to be recovered? No. When the trusts use the phrase “legacy debt”, they are referring to their assessment of what it will cost them to maintain service expectations as set by commissioners and the Department versus the amount of money that is available to them. They are talking about a forecast problem rather than a historic one.

The analogy that I would draw is with the figures in the Appleby report, in which the service assessed its needs as costing several hundreds of millions more than it was likely to have. The trusts are saying something similar: they are assessing what they need to do; they are considering the amount of money that is available, and they think that there is a significant gap. The trusts used the phrase “legacy debt” because they are suggesting that they had no option but to sustain the commitments that were entered into by former organisations. They are suggesting that there was, perhaps, not enough money around to sustain them. It is not a debt as such; it is an assessment of what they think they need to do versus what they believe they are funded to do.

The Chairperson:

I apologise to Mrs Kelly; I nipped in there and asked that question because I have asked the

Deputy Chairperson to take over for five minutes, and I did not want to come back to find that the question had been asked and that I had missed the opportunity to raise that issue.

(The Deputy Chairperson [Mrs O'Neill] in the Chair)

Mrs D Kelly:

Your answer reminds me of the old soap opera that used to be on television called 'Soap'. The catchphrase at the end of every show was: "Confused? You will be."

We are talking about efficiency and performance. At the outset and on a personal level, I am disappointed that, despite repeated requests by the Committee for the details of the Department's efficiency savings, we still do not have them. Those were requested several weeks before Christmas; that does not inspire confidence in the Department's ability to respond efficiently to Committee requests.

We are also talking about financial forecasts in a changed, constrained and challenging economic climate and in the light of the recent announcement about cuts in the Health Service budget. Efficiency and better performance are key criteria in meeting some of those challenges. The conversation thus far has been about trusts. However, the PA Consulting Group was commissioned to review the Department's top structures and published its completed report in August 2006. It made a number of recommendations about the Department that have not been discussed since by its management board.

Those recommendations were pertinent; the report said that there was a silo attitude to policy development and performance that was personality driven. How has the Department responded to the criticisms of its management structure? How much money will be saved as a consequence of taking those recommendations on board? The media and the public are saying that front-line services must be protected. You have, quite rightly, pointed out that management costs in the trusts are below 4%, but we do not know what the Department is saying about its own costs.

At this point, I should declare an interest as a former occupational therapist with a frozen Health Service superannuated pension. There are also concerns about outpatient waiting times and the impact of the recent poor weather on elective surgery as well as the need for more orthopaedic surgery. Those factors will have an adverse effect on allied health professionals.

It is interesting to note the conclusions of Lord Darzi's 'High Quality Care For All: NHS Next Stage Review Final Report'. The team here have told us that they still have centrally driven targets, but that is not the direction in which the Health Service in England is moving, which has been transformed and where there is a bottom-up rather than a top-down approach.

I am also concerned about how you define non-recurring costs. This seemed to be a stand-alone pilot project to improve performance in the Health Service. One trust bid for and received money and delivered a good model that was followed by other trusts and achieved a better outcome for patients and clients. That is not my understanding of what recurrent costs were in the past, and, having listened to these gentlemen, it seems to me that the Department does not trust the trusts in the management of their budgets, or when considering their long-term strategies. What exactly is the Department saying? The 2006 report clearly stated that there was no joined-up approach in the overall strategic vision and direction of the Department and the Minister.

Trusts have been left in a quandary. The trusts deal with the public at the coalface, while others in the Department, without that intimate knowledge, set centrally driven targets and maintain a top-down approach to the trusts.

Dr McCormick:

The member raised some interesting issues, and I will need to respond on several different dimensions.

I commissioned the 2006 report during the period of direct rule; it was useful because it allowed the Department to challenge several aspects of the way in which it worked. The report included the means not only to examine a top structure through the design of an organisational chart but, importantly, to challenge the way in which the Department worked to ensure that there was the right cross-fertilisation of ideas and the involvement and leadership of the different professional groupings in the Department. The report was discussed fully, and many aspects were implemented.

However, the report was somewhat overtaken when devolution was restored, and the Minister requested that the role of the Department be thoroughly considered as part of the review of public administration. That had a significant effect in many ways, including the fact that the Department

transferred some of its functions and resources to the new bodies that were created on 1 April 2009, with a material reduction in the number of departmental staff. That transfer was made to ensure that any duplication of effort was avoided between what the Department does with respect to financial management, creating strategy and policy, and supporting the Minister. That narrow range of key functions was reserved by the Department, because the Minister wanted those issues to be handled by the Department.

Mrs D Kelly:

Given that we are in the potential throes of local government and planning reform being made through RPA, did the budget follow the function?

Dr McCormick:

Yes, it did.

Mrs D Kelly:

In its entirety?

Dr McCormick:

The resources associated with activities such as the operation of the Health Service's superannuation scheme, and some of the information services that moved to the new Business Services Organisation and the Health and Social Care Board, were transferred and the Department's budget was reduced as a result. The Department is also subject to the general requirement for all Departments and the entire health and social care sector not only to deliver 3% efficiency savings a year but to hold to a reduction of 5% a year; that was the 2007 decision across Departments to deliver that scale of reduction.

The Department will supply the member with the details that she has requested on efficiency savings being secured. I am sorry if that has been delayed.

The Minister is as committed and determined — as all colleagues here are — to ensuring that the Department is as lean as possible but still able to fulfil its functions. It is about finding that balance. The Minister requires that work and support in order to handle his official functions and to look after strategy and policy. He wants the Department to retain a significant role on financial management, capital planning — that is John's function — and to have oversight of aspects of the

HR function for the health and social care sector. The RPA decision was that those functions should remain in the Department, and they have done so. It is a question of ensuring that the Department is fit for purpose and able to function in that way.

Some lessons from the 2006 report still stand, such as those on how we work and how we avoid handling matters on a silo basis. Different professional disciplines, such as the Chief Nursing Officer, the Chief Pharmaceutical Officer and the Chief Dental Officer have contributed, and they have the chance to operate across the functions. A key theme of the report is to ensure that professionals have significant policy and executive responsibilities. That process started several years ago in some aspects of the Department's activities. We are continuing to develop that theme to ensure that we have the right inputs and that people are doing the right job, providing the right advice to the Minister and offering the right leadership to the system. We are conscious of those responsibilities, and we seek to work effectively.

I will address the issue of the approach to waiting times. That is down to the challenge about the degree of trust in trusts, and so on. We have adopted an approach to performance management that involves setting targets and holding people to account for their delivery; that happened in England several years ago. We are, perhaps, a number of years behind England in starting that process, which has had conspicuous success. England has reached a stage at which trusts are delivering elective care, not on the basis of three separate targets of nine weeks, nine weeks and 13 weeks for three different stages with the possibility of a gap between those stages. That represents a total journey time of at least 31 weeks in our context, in which trusts are delivering on those targets. In general, England achieves a total journey time of 18 weeks.

The Government recently made a commitment, which was outlined in a document by Secretary of State for Health Andy Burnham, to create a statutory obligation of an 18-week patient pathway. Therefore, the Government are not allowing trusts to determine their own waiting times; on the contrary, they are moving beyond setting targets to setting a statutory requirement. If a patient does not receive treatment within 18 weeks, he or she can use the private sector at that trust's expense. That represents a move from a performance management approach to a statutory approach, which is even stronger.

There is a strong school of thought to support that approach. I am familiar with some aspects of Lord Darzi's proposals. Trust is important, and organisations generally perform better when

they are allowed to proceed with clear objectives and appropriate resources and are held to account for delivery rather than micromanaged. That is a good philosophy, and we would all like to be in that position. The difference is that we are still on the pathway towards achieving elective waiting times, unscheduled care waiting times and wider service standards that are acceptable. At that point, we can stop in the knowledge that the public are happy that the service is being sustained and delivered consistently. We have not yet secured that end. Holding trusts to account does not signify distrust; it is simply good performance management. It follows the English example and seeks to secure the same kind of outcomes.

However, I recognise the fact that the best way to achieve that is to ensure that clinicians in all professional groupings are committed to the process and are clear that the overriding objective is to do the best for the patient. When I deal with performance management in trusts, I consistently say that the targets are a means rather than an end. The aim is to deliver the best possible care, and nobody should ever do the wrong thing in order to meet a target. Therefore, we must find the right balance and the right organisational dynamics. That is challenging. There are different philosophical approaches, and David Cameron and the Conservative Party have a different point of view. Those are interesting ideas, and the devolved Administration and the Minister must decide on the best approach in the context that we have not yet achieved some significant standards. England has moved from improving targets to consistently reaching standards.

Mrs D Kelly:

Was England able to meet targets and make progress because it was better resourced? Was there better upfront investment in those services?

Dr McCormick:

It is always difficult to be sure of the precise cause and effect. Clearly, it is a fact that the level of investment and the rate of growth of spending from 2002 to the present day were larger and more rapid in England than here. We started with a higher level of spending per person. However, the point that the Minister has made, which has been explained many times, is that through the needs assessment methodology that the Treasury used first in 1979 and applied consistently throughout the 1980s and 1990s, and which was used by DFP earlier in the past decade, health and social care in Northern Ireland received less than it needs according to the evidence-based approach.

Therefore, the short answer to your question is yes; England has better resources. It is

important to state that that has neither been our excuse nor our sole focus. On the contrary, we have said that, whatever our level of resources, we expect better delivery. Many aspects of the improvement of waiting times and, say, reform of accident and emergency provision are procedural and management issues that can be improved without additional resources. Many aspects of that relate to how things are done and whether engagement of clinicians is correct and the right organisational steps have been taken. Many steps can and have been taken. The trusts have worked hard to deliver significant improvements in performance, many aspects of which are not resource-dependent. Therefore, England has more resources, but that is not the only issue. No one uses that as an excuse for underperformance.

Mr Donaghy:

I want to pick up on one point briefly. I suspect that I am personally to blame for the failure of the Committee to receive a response. I apologise for that. A response is prepared. I have authorised it. I am at a loss to understand why you have not received it. When I return to the office, I will ensure that you receive it. I apologise personally.

Mrs D Kelly:

It is always good to know that someone is accountable.

Mr McCallister:

That is a bit of a shock.

Mrs D Kelly:

We must look him in the eye. It is seldom that such an honest, hands-up approach is taken.

Mr Donaghy:

I hope that I will not have to be that honest too many more times.

As regards waiting times, you referred to the recent cold snap, which was an exceptional and unpredictable period for all of us. It may have an adverse impact on waiting times, particularly in areas such as orthopaedics. We hope that it will be modest. We will continue to manage it. I am not sure that we could have done a great deal more to prevent that, given that the cold spell took us all by surprise. I just want to acknowledge that there will be some impact, although we hope that it will be very much at the margins. We will continue to manage it to ensure that it has the

least possible impact.

Mrs D Kelly:

Of course, you could use some of your non-recurring budget to invest in those areas that are at risk of extended waiting times.

Mr Donaghy:

Andrew sought to explain earlier that we do not have a non-recurrent budget that we can use.

Mrs D Kelly:

None at all? I am sure that you have some money somewhere.

The Deputy Chairperson:

They have had money at different times throughout the years.

Mr Donaghy:

The service costs £4.2 billion per annum to run.

Mrs D Kelly:

When I worked in the trust, we used to call it “slush money”.

Dr McCormick:

That must be something to do with the thaw.

Mr Donaghy:

I have not heard any of the trusts say that they have slush money available to them.

The Deputy Chairperson:

We are running out of time.

Mrs McGill:

You are welcome. Thank you for your briefing. The report refers to good practice and bad practice. One example of poor practice throughout the system is the employment of management consultants and specialist advisers. With regard to the Western Trust, the report gives a particular

example that reflects a decision that was taken by the Sperrin Lakeland Trust. It states that the Western Trust incurred a cost of £2.4 million through the employment of specialist advisers without having obtained specific DFP business case approval.

Given that the report refers to 2007-08, and we are now in 2010 and budget cuts are to be made, what has the Department learned from that example of poor practice? In what way will the Department roll out whatever recommendations are deemed necessary to address that?

The Deputy Chairperson:

That topic lies outside today's discussions: we are dealing only with performance. However, please answer if you can. I am sure that Claire would appreciate it.

Mrs McGill:

It may be outside performance in one way, but if you look at it in another way, it comes within that section. *[Laughter.]*

(The Chairperson [Mr Wells] in the Chair)

The Chairperson:

It is me you are talking to. Do not keep following Michelle around the room.

Mrs McGill:

I am keen to know about that, because if £2.4 million was spent on consultants and advisers, that would have an impact on what the Western Trust could deliver to the front line.

Dr McCormick:

We have tight procedures for the approval of consultancy across all organisations and in all aspects of what is needed. We have very strict criteria as to when consultancy may be used. The case to which you refer is where the Sperrin Lakeland Trust committed more expenditure than it approved. When that was put to the test, the issue was one of approval. Had the case been made properly, the expenditure would have been approved because it was justifiable. It was appropriate in the context where the PFI project, in relation to the hospital that was being considered, was breaking new ground. It was an unusual case in the UK context and specialist advice was necessary. It is akin to what we said about the independent sector earlier; it would not

have been appropriate for us to attempt to employ people with that expertise because we would not have needed them in perpetuity. We use management consultants where specialist input is needed for a temporary period.

Mrs McGill:

I know that the Deputy Chairperson says that this is outside the remit, but if you will allow me —

The Chairperson:

If she says it is outside the remit, I will probably say the same.

Mrs McGill:

Nevertheless, I want to make the point that the employment of consultants and specialist advisers is an area that, in view of budgetary constraints, needs to be examined. If the Department and the trust can afford that kind of money for consultants and advisers — £2.4 million or whatever — and front-line services will be affected, that needs to be addressed in this discussion.

Dr McCormick:

We will need to scrutinise that very carefully.

The Chairperson:

We will return to that issue when we discuss other sections of the report, so some of that will be relevant at that stage.

We have gone well over time, gentlemen. We kept you late on 21 December, and you lost the opportunity to attend your Christmas party, and we have kept you too long today. Thank you very much for your help on this matter, and we will be seeing a lot of one another over the next few weeks as we move into the Budget period. Have you any last points to make?

Dr McCormick:

No. Thank you very much indeed.