Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Presentation by the Minister on Departmental Spending Plans

28 January 2010

NORTHERN IRELAND ASSEMBLY

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HEALTH, SOCIAL SERVICES
AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Mr Alex Easton
Mr John McCallister
Mrs Claire McGill
Ms Sue Ramsey (Acting Chairperson)
Mr Conall McDevitt

Witnesses:

Mr Michael McGimpsey	) Minister of Health, Social Services and Public Safety
Mr Seán Donaghy	)
Mr Seán Holland	) Department of Health, Social Services and Public Safety
Dr Michael McBride	)
Dr Andrew McCormick	)

The Acting Chairperson (Ms S Ramsey):
I welcome the Minister. I have drawn the short straw; within two minutes I have been elevated to the position of Acting Chairperson. I must have been bad in a previous life. There are four members present, so we cannot make any decisions, but we can take evidence. I know that you are very busy, so rather than making a long introduction, I will hand over to you to introduce your team and then take questions.

The Minister of Health, Social Services and Public Safety (Mr McGimpsey):
I am happy to do that. I congratulate you on your elevation, and commiserate with Jim; I

understand that his wife is not well, and I hope that things get better for her. I know that Michelle is also ill. You are right that we are busy: I am supposed to be at Hillsborough right now talking to the Secretary of State, but this is more important than anything that is going on at Hillsborough. We are here to speak about the funding of the Health Service and the latest proposals, which the Finance Minister inadvertently referred to in his address to the Assembly as his “daft proposals”. Having read through them, I think that that is a very apt description.

I will make a statement, and I will then be happy to take members’ questions. I am grateful to the Committee for this opportunity. Anyone would imagine that a Health Minister and a Health Committee had a shared objective: enabling access to the highest-quality health and social care services for everyone in Northern Ireland. That sets the UK aside from all other western countries — cradle-to-grave healthcare that is free at the point of delivery. In the States, for example, people pay for insurance; in the Irish Republic, France and Germany there is a mixture of free delivery and insurance, but there is an element of pay. We are the one country in the world where Bevan’s principle came forward first: delivering cradle-to-grave healthcare free.

The old adage is that if one does not have one’s health, one has nothing. The efficacy of health provision in this country is amply demonstrated by the huge improvements in, for example, average life expectancy in the UK, which has grown dramatically. Health and social care are some of the key reasons for that improvement. There have been many successes in Northern Ireland since I took up office; most notably, there has been a huge drop in waiting times for surgery, and I have made a significant investment into long-neglected areas such as mental health and learning disability. Today’s Health Service treats thousands more people every year and provides a greater range of services than ever before. Nevertheless, we have a long road to travel before we are on a level playing field with the rest of the UK.

Compared to England, our funding gap now sits at nearly £600 million; our spending does not match our needs, which are significantly higher. How are we supposed to catch up with England, Scotland and Wales when our funding is cut while demand continues to rise sharply? I firmly believe that people in Northern Ireland deserve the same quality of healthcare as those in the rest of the UK. Spend in Wales and Scotland is marginally ahead of that in England; therefore Northern Ireland is the poorest region, and the gap between us and the rest of the UK is extreme.

I come here today with no other purpose than to seek your support in protecting our Health

Service and ensuring that it is exempt from more damaging budget cuts. I make no apology for once again spelling out the scale of the challenges: we must achieve £700 million efficiency savings by next year. If the service were properly funded, as it is in England, that could be done; in Northern Ireland, where it is underfunded, it is much more difficult. Scotland is not looking for 3%; it was decided that the Health Service was too important, so the efficiency savings that its Health Service has to achieve were reduced.

Nevertheless, we have to make efficiency cuts amounting to 3% per annum; that adds up to a composite of about 10% of the budget. Although we get to re-invest that, taking money out to put it back in is very expensive, not least because our major costs are staff and superannuation. As staff come out and staff go in, the superannuation costs, under the new regulations, simply double. That would lay heavy penalty on us. It is no easy task when the service is struggling to meet huge increases in demand.

Trusts' plans for efficiency savings can cause considerable pain for a service that has been cut back to the bone. In fact, there was outrage and anger from some members of the public — and some members of this Committee, who are now absent — who were vocal in demanding efficiencies, yet when the proposals for efficiency cuts were made, those same people were the most vocal in demanding that those efficiencies be scrapped. That has not been the case for any other Department; all other Departments have easily met their efficiency targets, because all other Departments have margins that they can play with. That is not the case in the Department of Health; we are right on the edge.

There is huge public interest in health, because it matters to every man, woman and child. Health is precious and vital, and it needs to be protected, not attacked. We are talking about alleviating pain and distress in our population; we are talking about life and death.

It is proposed that the Department's budget will suffer another devastating blow: it will have to find a further £113 million to address the "made in Northern Ireland" financial problems. Those financial problems have nothing to do with London or Gordon Brown; they are due to the fact that the Department of Finance and Personnel has discovered that it needs a fast £400 million, and it is making the Department of Health, Social Services and Public Safety pay an almost pro-rata payment to apply a fig leaf to that problem.

The pro-rata cut means a reduction in the Department's budget of £113 million. The current proposal is for a cut of approximately £105 million, and it is being trumpeted as a less proportionate cut than any other Department's. However, that is pure deviousness in presentation; it is tokenism.

The proposed cuts do not reflect the priority that the public attaches to health. Indeed, it was interesting that during the recent talks at Hillsborough Castle anyone who spoke to the media, from the Prime Minister down, said that instead of being at Hillsborough talking about policing and justice, we should be in Stormont talking about the things that matter. The issues that all the parties want to talk about are education, the economy and, always, health.

It concerns me that the Department faces such cuts, as demand for health and social care services is rising at an unprecedented level. For hospital services alone, the figure has increased by 20% in the past two years, and the latest figures show a 19·3% increase in day-case admissions since 2004-05, a 7% increase in the number of inpatient admissions, and almost 584,000 admissions to hospitals across Northern Ireland since 2004-05, which is a 12% increase. Trusts are struggling to meet the growing demand, which is evident in the deficits that many are reporting.

Some of our most vulnerable groups are the biggest users of the Health Service. People use the Health Service for the first 10 years and the last 10 years of their lives; those are the folks who need the Health Service, and when it hurts they will pay the price.

Northern Ireland has the fastest growing elderly population in the entire UK. At present, the over-65 population makes up 15% of our total population, but it accounts for 40% of emergency admissions to hospital. Those aged 75 and over require five times more support than the average Health Service user, and those aged 85 and over require 14 times more support; in the next two years the number of those aged 75 and over will rise by 10,000 and those aged 85 and over by 5,000. In addition, approximately 16,000 people here suffer from dementia, and that figure is expected to double in the next seven years. Despite that, the Department is being asked to cut back or to stop providing care to older people in their homes and in hospitals because it cannot afford to do so.

If those services are cut, how can that gap be filled? There is already a struggling carers sector

here, with a quarter of the approximate 180,000 unpaid carers providing around 50 hours of care a week. The support that they receive enables them to provide that care, but further reductions will cause a hugely detrimental effect and bring about huge pain. Carers are twice as likely as the rest of us to be sick and disabled themselves, yet if we reduce spend in the Health Service and its capacity to deliver, a bigger burden will fall on them.

The birth rate in Northern Ireland is also rising, and in the past two years there have been approximately 3,000 unanticipated additional births.

Maternity services are in desperate need of additional investment to help them to cope. For example, one of the key elements of the investment that is required is a new maternity hospital and a new children's hospital for the Royal. We should be talking about need there. We need an investment of more than £300 million to fix that, but I do not have the support to do it.

Children's services in Northern Ireland are underfunded by more than 30%, when compared with England; about 100,000 children in Northern Ireland are living in poverty, and some 11,000 children live with domestic violence every day. There has also been a huge rise in the number of children on the child protection register; last year, it increased to 2,500, which is a rise of almost 500 cases. On top of that, the number of children referred to social services has risen by a third over the past few years. How are we supposed to bridge the gap between the historical underfunding of children's services and the growing need while we are in the teeth of successive cuts to healthcare? Our aim is to support families to stay together and to protect children. Early intervention and the early identification of risk are vital to ensuring that that happens. That requires investment in social services and in the teams that have been set up to help struggling families.

I have already invested significantly in those areas, but much more is required. If I am forced to cut funding for children's services, early intervention will no longer be possible. Social workers will have to focus on child protection and families in crisis instead, and we will run the risk of children living with neglect and abuse for longer.

One in six people here suffers from mental illness at any one time. Our mental health needs are 25% greater than in England, yet we spend 25% less to address them. That means that people in Northern Ireland do not yet have full access to talking therapies, which was a key part of the

Bamford review proposals in preventing admissions to hospitals. However, that situation is not through choice. The historical and continuing lack of investment in community mental health services has resulted in some patients remaining in long-stay hospitals.

An estimated 16,000 people in Northern Ireland have a learning disability. Improvements in healthcare and increased support mean that that population is living longer than ever before — thank God for it. Great strides have been made in ensuring that the permanent address of people with a learning disability is no longer the hospital and that those people are resettled in the community. However, the costs of resettlement are significant.

I am simply stating the facts. I have been Minister of Health for almost three years, and I have seen at first hand how hard our staff work. I have met people who have a learning disability or mental health problems as well as their families to understand the difference that good-quality mental health services can make to their lives. I keep getting questions about how much the Department spends on postage stamps and taxis. Does anybody really imagine that cutting back on postage stamps will solve the problem? It would simply mean that patients would not receive letters from hospitals, GPs or consultants.

One of the reasons that we use taxis is to transport children in care, because they are vulnerable to an estranged partner. If a child has been removed from his or her home and is taken into care because of abuse or neglect, taxis will take him or her to school. We either do that or we get a social worker to ferry the child back and forth. That would be ideal, but we do not have that sort of money, so we use taxis. I know that a member of the Committee suggested that we use a van, but that is no way to treat youngsters.

One of the groups that will be hardest hit by the latest proposed cuts will be carers. I have talked about carers delivering an incredible £3·2 billion of care every year, and they do that for free. If one adds up the number of hours that carers provide and equates that with a simple cost, the total is well over £3 billion. We need to provide them with the support that they require. That makes economic sense if one wants to talk about the issue in terms of money. Although I have to make the savings that are being asked of me, it is not acceptable to place a greater burden on carers' shoulders. Our needs — this has been tabulated — are 14% or 15% greater than those in the rest of the UK; our social care and healthcare needs are higher than those in England. Put simply, that equates to about £600 million. That is roughly what we spend on caring for older

people every year. The services are inadequate, but that is what they cost; that is the difference between our spend and the spend that we would be allowed at English rates according to our need.

As I said, people use the Health Service most during their first 10 years and their last 10 years, so the cuts will fall on the shoulders of those least able to bear them: the frail, the elderly, children and the disabled. That is not equality. I will talk about equality in due course as well.

However, making our health and social care services more efficient is essential if we are to use our limited resources better, and we are doing exactly that. Our productivity is improving; in the last two years alone, it increased by 7%. My Department is still the only one to have completed the review of public administration reforms; we have gone from 18 hospital trusts to five, from four health boards to one and so on. I have put in place those reforms; no other Minister has done so. I am the only one. I put through the legislation with the support of the Committee. We have cut hundreds of administrative jobs and more than halved the number of senior executives. For example, we now have five chief executives in hospital trusts doing the work formerly done by 18.

If we were to take every administrator and manager out of the system, it would still not fix our financial difficulties; indeed, it would only place an additional burden on nurses, doctors, social workers and staff. No one seriously believes that we should ask our nurses and doctors to answer media inquiries and deal with the large number of costly Assembly questions and freedom of information requests.

The last time that I came to the Committee, I asked for members' unanimous support in lobbying to ensure that the health budget will not be raided to bridge this gap. I asked for your support in the fight for more funding for the Health Service. If these cuts proceed, the consequences will be severe. They will affect our most vulnerable groups, especially the elderly, who require more care and support than anyone else. Our health and social care staff are stretched to the limit to meet these additional demands; they simply cannot stretch any further.

The Acting Chairperson:
Thank you, Minister. I have just a couple of points to make. You do not suggest that we should not hold officials to account or fail to ask questions. As elected representatives, that is our job,

and I and others are entitled to answers to our questions.

The Minister of Health, Social Services and Public Safety:
I am not suggesting that you should not ask questions. However, I have answered 5,000 Assembly questions; many, many more than any other Department. I keep answering the same questions over and over. I do not refer to you, Chairperson, but at £300 a question, some discipline is required.

The Acting Chairperson:
I know that; and I know you do not refer to me. However, you also said that health issues affect everyone, so we need to know what is going on.

On the issue of taxis, I take your point with regard to children. I raised that point, and I am aware of the work that social services do to ensure that that is done privately. Concern was raised that health records and blood samples were delivered in taxis, so privacy was not the only issue. I would fight as fiercely as you or Seán to ensure the privacy of children so that no one knows that they are attending a day centre, and in those circumstances the use of a taxi is preferable to that of a large yellow bus. However, use of taxis to deliver records and blood samples from one side of the hospital to another raises the issue of efficiency.

The Minister of Health, Social Services and Public Safety:
Please allow me to intervene briefly. A consultant may require records immediately to address certain situations; perhaps Dr Michael McBride could pick up on that. I should also point out that blood samples deteriorate swiftly.

Dr Michael McBride (Department of Health, Social Services and Public Safety):
I have no wish to prolong the discussion, but the Minister makes a valid point. To provide effective and safe care for individual patients or out-patients, it is important that medical records be available. A huge team of administration and clerical staff does a crucial job in ensuring that records are available; they provide an excellent service. There are occasions when records are not immediately available because we provide care across the service in Northern Ireland or, as the Minister said, where there is a need to get a sample to a laboratory urgently to determine appropriate intervention for a patient.

We have 584,000 admissions each year and we see millions of outpatients each year and, in a system that delivers that level and quantum of care, such situations will arise. We will continue to deliver for the patient. We are here to serve the patient, and we will ensure that we deliver optimal care for them. If we are required to use taxis in certain circumstances, we will do that. Ultimately, however, we want to ensure that the patient receives the best and most timely care.

The Acting Chairperson:
We were talking about public opinion. We have heard that £500,000 was spent on taxis in six months; that figure must be broken down. In my constituency, porter positions were not filled, but additional money was spent on taxis. That does not sit right. I take the point that some money needs to be used, but does all of it? Porters, who could do such deliveries, have not been employed.

The Minister of Health, Social Services and Public Safety:
The public deserves the right information: it does not deserve banner headlines saying that we are, apparently, wasting large sums of money here, there and everywhere when that is not the case, especially with regard to taxis, as I have explained. Such easy headlines do no service to the public or the patient.

The Acting Chairperson:
Let us try to get into the substantive part of the issue. At the meeting of another Committee of which I am a member, departmental officials analysed the impact of the recent DFP statement and told us where savings could be made. I see nothing from the Department of Health on that issue. The unions, who will be appearing before the Committee next, say that there is no material on the Department's website where people can see the impact of the savings. They also suggest an equality impact assessment. Will the targets in the Programme for Government be met?

The Minister of Health, Social Services and Public Safety:
I will run through that quickly. I have notional plans, but at the minute I am looking at proposals, and those proposals will run only if you and everybody else in here vote for them. The same applies to the Assembly. I will be asking the Assembly also to reject the proposed cuts — as the Chairperson of the Committee, when he was Deputy Chairperson of the Committee for Regional Development, rejected the £80 million cuts proposal from the Minister for Regional Development. I will produce plans when I am absolutely certain of what I face; the trusts are

working on plans.

I will give the Committee a rule of thumb. Thirty jobs cost, roughly, £1 million. We are right on the edge; there is no fat — it has all been removed. We are not like other Departments. I can go through other Departments and explain their pro-rata overspend vis-à-vis England. They are substantial and would probably surprise members. According to our need, we are massively underspending. Three quarters of the budget is spent on people, so if cuts were calculated purely on labour, it would equate to 2,500 to 3,000 redundancies.

I will relate that to facilities. Imagine that I am looking for £100 million in cuts. It costs roughly £50 million — or slightly less — to keep the Mid Ulster Hospital or the Mater Hospital running for a year. I could make cuts there, but I will not. I will do something that will have a more dampening effect. In effect, the 31-week period for total journey time, appointment, diagnostics and treatment — which is much higher than the English 18-week period — will run out. If I do not have enough money to cover rising demand, everyone will have to wait that wee bit longer. Therefore, I will work all that out, and I will be able to demonstrate that.

Every time I come here I feel as though I may as well be talking to the wall. Since the original budget was set three years ago, I have been saying until I am blue in the face that there is not enough money in the system to do the job. If the budget is reduced, we will be unable to do the same amount of activity; we will not do the same job as we are doing now.

The Acting Chairperson:
I am sure that you will have to draw up plans to implement the statement from the Minister of Finance. We should have that information.

The Minister of Health, Social Services and Public Safety:
I do not have plans for that. The draft cuts are so big and so painful that I should not be facing them; I should be looking at increases not decreases. Professor Appleby, who conducted the last efficiency exercise four years ago, said that health should get 4·3% per annum real-terms growth year on year. This year, demand is up 9%, but our real-terms increase is 0·5%. The other factor that must be included is that demand was up 12% last year, and I have given you some of those figures.

Late in the day, the Department of Finance said that it needed to find £400 million quickly, because it had not worked out that it needed that amount of money, and now it is hitting me for more than £100 million — if you vote for it. I ain't going to vote for it. However, if I am placed in that situation, I will have to tell trusts that they must make draconian reductions in their spend, and that will mean reducing their activity. If the money in your purse is less than you need, you do not have enough to buy what you need. We are already in that situation; activity will go down.

The Acting Chairperson:
Will the £116 million for technical changes be used for pension changes, or can it be used for service delivery?

The Minister of Health, Social Services and Public Safety:
What are you referring to?

The Acting Chairperson:
The current expenditure budget has increased from £427,300,000 to £429,800,000, and it is based on an additional £116 million for technical changes.

Mr Seán Donaghy (Department of Health, Social Services and Public Safety):
Perhaps I should reply to that.

The Minister of Health, Social Services and Public Safety:
I should have introduced Seán Holland, who is the head of Social Services; Michael McBride, who is the Chief Medical Officer; Andrew McCormick, who is the permanent secretary; and Seán Donaghy, who is the financial deputy secretary.

Mr Donaghy:
Some weeks ago, the Committee Clerk relayed a query in respect of the technical changes, and our response at that stage was that the technical changes are just that: they are figures advised by DFP to render consistent comparisons from year to year. It implies no increase whatever in spending power. There is no increased spending power to help to do more with that funding. It is simply a reflexion of consistent presentation of figures across all Departments.

The Minister of Health, Social Services and Public Safety:
You asked about an equality impact assessment, which is crucial, as it will show that the first section of our population to be affected by a £100 million reduction will be children and the elderly. They are the biggest users of the Health Service. We use it in the first 10 years of our lives and in the last 10 years, so children and the elderly will pay the price for that reduction. Therefore an equality impact assessment needs to be done.

I am concerned, because DFP is supposed to do this, and, as I understand it, it says that the pro-rata cut of £113 million is the base. It is actually cutting us by between £105 million and £106 million; therefore, it will carry out an equality impact assessment on the difference. It will carry out an impact assessment on about £9 million or £10 million only when it should be doing an assessment on £106 million. That is crucial, because the most vulnerable members of our society will hurt the most, and the Committee must have a strong view on that. I have had a discussion with the Chairperson about the issue, and I know that you are talking to staff side shortly. We all have a strong view on the issue, which is that the Health Service is there to protect the most vulnerable members of our society. No one is more vulnerable than those who are in pain and distress, particularly in the age groups that we will be hurting. The patients in 90% of the medical beds in hospitals are over 65. That is a fact. If I have to reduce medical beds, that sector will be hurt the most. It is a simple to try to get around that by taking the difference between pro rata cuts and actual cuts and by talking about doing an equality impact assessment for £9 million or £10 million instead of £105 million. I do not think that that is the way in which we anticipated that equality impact assessments would work.

Mr McCallister:
Minister, you are painting a fairly gloomy picture. One positive aspect that I have taken out of your statement is that productivity is up by 7%. However, even at that, demand is outstripping it by rises of 9%, 10%, 11% and 12%. Even the Committee was surprised by evidence from the trusts, which stated that administration and management costs were, on average around 4% and, in some cases, below 4%. I think that would compare favourably with other Departments. I am sure that if we looked at a budget such as that of the Department of Agriculture and Rural Development, your Department's administration budget would compare favourably.

You have to make savings of £113 million, and you also took the biggest hit on swine flu. The Health Department started off from a base of £600 million behind the rest of the UK. That is

an enormous shortfall. It is likely that waiting times will go up. Where does that leave such issues as our new service developments, which included some of the things that you had wished to do? Mental health is included in those services. Figures that were released yesterday or the day before show that the gap between rich and poor across the United Kingdom is wider than it has been in the past 40 years. The gap between rich and poor in Northern Ireland will increase dramatically. There will be increased health inequalities between those living in Cultra and Creggan, for instance. You touched on the equality agenda, but budget cuts will blow open the equality agenda.

All members of the Committee have said that we focus a lot on secondary care in hospitals, so I was pleased to hear you speak about our young people and elderly people. In the past, we have said that mental health was the Cinderella service and the service that was easiest to cut. I have a big concern about cuts and the impact that they will have on children's services, the elderly population and those who do a lot of unpaid care work for them.

The Minister of Health, Social Services and Public Safety:
If one is looking for savings of £105 million, one does not carry out the new activity that was planned. We had planned new activity next year, as part of our service development, but, as I said at the time, our budget was not large enough. It was as good as it would get, but it was not enough, and we fought that to a standstill. However, I did not have the votes in the Assembly to support my argument.

The main bulk of the service developments will come next year, and we have around £74 million of service developments. If I were to try to hold the activity as it sits, the new service developments would be hit. The biggest winner next year — if we can call it a winner — will be the area of mental health and learning disabilities. We are putting £27 million into mental health services; £21 million into the treatment of long-term conditions and £17 million into provision for learning disabilities. We are putting money into cardiovascular, stroke, cancer and children's services. We see opportunities to make major improvements in those services, and they are services in which there has been historic underfunding.

I have been in business all my life. If a business owner wants to introduce a new activity into the business but has to trim back, he or she does not buy a new digger, for instance. If you are in the building trade, as I was, you sit tight instead of buying another acre of land. That is the

obvious stance to take on the new activities, and it will have the least effect on staff.

How will patients be affected? We cannot maintain children's services without extra investment. That will mean that services such as child protection, which helps children who suffer neglect and live in households with problems like drug dependency and domestic violence, will be hit. Cancer screening and access to new drugs will also be hit.

At the time, I explained to the Committee where I anticipated the money going, and I have done so since. That is an option, which is why I am not being hard and fast in my plans; I want to see all that the proposals entail. Alternatively, I could make cutbacks to my Department's activities. What services should we cut? Should we start with older people's services, acute services, children's services, cancer services or GP services? That is the choice that we face. Those questions are in the mix. As I said, no matter how it is done, there will be serious pain.

It escapes me how an equality impact assessment on the proposed spending plans could have a positive result; it is not possible. The effect will be massive. I am not here to make comparisons with other Departments, but some of them are in a better position to handle the proposed spending plans than my Department.

Four or five years ago, a productivity exercise by Professor Appleby on hospital services in Belfast made 26 recommendations. Of those recommendations, 25 were for the Department of Health, Social Services and Public Safety, and all of them have been acted upon. The other one, which was for the Department of Finance and Personnel, recommended a 4·3% year-on-year increase, in real terms, for the health budget to bring healthcare in Northern Ireland up to a comparable level with that in the rest of the UK. That has never been done. Our increase last year was 1·1%; this year it is 0·5%, and next year it will be 1·7%, so we are miles behind.

The gap is increasing and demand is rising. If there is a 9% rise in demand and a 0·5% rise in resource, everybody will have a worse Health Service. Through productivity, through RPA and through the fantastic effort of staff throughout the health and social services sector, we have stretched to cover that deficit to date. However, there is unmet need, the level of which is bound to rise.

Mr McCallister:
You mentioned the Appleby report a couple of times. One of the key responses to that has been the establishment of the Public Health Agency, which I support. Delivery on some of the other recommendations, such as addressing health inequalities, will be completed in the medium to long term; such issues will not be resolved by a quick response.

Does a budget cut, such as the one proposed, make it significantly harder to deliver investing-to-save measures?

Dr Michael McBride (Department of Health, Social Services and Public Safety):
The answer to that is a clear yes. The sums are quite simple. The proposed spending plans will have profound results for healthcare. As the Minister outlined, even if we did nothing next year and made none of the required investments, we would still have to find an additional £20 million. As the Minister indicated, that would mean an end to the Executive's approved plan for the implementation of the Bamford recommendations; the £26 million investment in mental health services; the £17 million provision for those with learning disabilities; and the resettlement programme for patients of Muckamore Abbey.

As the Minister also said, it would affect the provision of new drugs. The situation in 2005 was scandalous: people with rheumatoid arthritis were waiting for three years to access drug treatment. Our Minister invested £10 million to reduce the waiting time to 21 weeks. It is planned to invest in all of those areas next year because of the impact that they will have on individual patients. I know that investment in stroke services is a subject that is very close to John's heart. We invested £9 million to make thrombolysis available to patients 24/7. All of that investment is before we even get to the upstream issues, such as bowel cancer screening and the HPV vaccination for young girls. Investment in those areas will prevent 20 deaths from cervical cancer and 70 deaths from bowel cancer each year in Northern Ireland. We intend to extend the breast-screening programme for women. However, if we have to find an additional £100 million, which is being proposed by the Executive, we will have to look at the affordability of all that upstream investment.

Make no bones about it: if that reduction is agreed, it will have a profound impact on the health of Northern Ireland's population and on our ability to do the right thing, which is to turn off the tap over time to reduce the demand for acute services. As the Minister has said before, it

is about moving from providing a sickness service to keeping people healthy and well. The people who will suffer in all of that will be the most vulnerable in society, such as those who live in deprived areas, children and older people.

Mr McDevitt:
I thank the Minister for his statement. There is a change of the guard in my party, but we will continue to offer constructive support where possible. However, I am deeply uncomfortable sitting here this morning. Minister, I suspect that you would find it very unsettling if you heard news that orthopaedic surgeons were being asked to make clinical decisions without access to proper x-rays or other diagnostic tests. However, you are asking us to formulate an opinion on a very serious topic without giving us the information that we obviously need to be able to do that. That is bad for this Committee, and it is unfortunate for you. It has the potential to put us all in a compromised situation in the months ahead.

To be honest, this meeting is only really poking around in the dark, but I am going to have a poke and ask you a direct question about zero-based budgeting in your programme activities. Do you continue to look at every programme year in, year out? Do you continue to identify the opportunity for savings? Do you continue to measure the output of every programme that comes through your Department? What levels of savings will be achieved in 2010-11? What programmes are underperforming and could give us an opportunity to release funds or invest in essential programmes that target the sort of issues to which Dr McBride referred?

The Minister of Health, Social Services and Public Safety:
I will ask Andrew to reply to those questions. The answer, of course, is yes; we are constantly looking at where we can make savings. We will make them where we find opportunities to do so, but we will not hand away savings to some other activity: the savings will work in the Health Department.

We are seriously underfunded, so everybody is in the business of making budgets stretch. That is a constant activity throughout the Health Service. In a Health Service that employs nearly 70,000 people and will spend around £4·2 billion this year in resource to provide millions upon millions of treatments, I am not pretending that there are not areas in which we can find savings. Of course there are, and we constantly look for those. Our productivity is up substantially, and very substantial savings have been made over the past three years.

However, we might not have enough money to fund activity. You want to know about plans. I have laid out where we will spend our money, but that will not make any difference: if money is cut down, activity will be cut down. Mr McDevitt mentioned orthopaedic surgeons. I am sure that he could provide other examples. Health is about assessing need and then addressing it. That is how it is done. What you do not do is say that the cake is only so big and that, therefore, we will take one slice and give it to the Health Department. Although that slice may be the biggest slice, and is, therefore, assumed to be enough to make do, that is not the case. Further, it is far from true that, if we were more efficient, we would be able to make do.

Over and over again, I have stressed the fact that not enough resource is devoted to health in Northern Ireland. The Northern Ireland block grant is around £19 million, and a slice of that comes off the top to form the unmanaged part of the Budget. That is the money that goes on pensions, unemployment benefits, sickness benefits and so on. Below that line, is a managed block, and the health budget is taken from that money. However, in my view, the health budget should come out of the unmanaged half of the Budget. The Department of Health gets around 43% of the managed block. That is less than half of less than half, yet I am constantly told that we are getting more than half the Budget, as though that makes a difference.

The key is to assess and to address need. I have told the Committee on a number of occasions what will happen if we do not address need and money is taken away. Members are all aware of that situation, asking me, as they do, questions on unmet need. If that situation arises, we will create more unmet need. It is as simple as that. The question that I have to answer is where do I take money from? Do I take money away from older people's services, from children's services, from cancer screening, from drugs, and so on? That is what I am being asked to do, and that is what the Committee is being asked to do. However, I say that we cannot do that. As it stands, I cannot even manage activity with the budget that I have, never mind if that budget is further sliced because DFP has suddenly discovered that it needs a fast £400 million.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): We have been looking hard at all aspects of the budget and not just in the immediate context of the sudden response to the need for cuts in services. Even when things were better, during the period of growth, demand always outstripped resources. That meant that every year, for the past decade, there was a need to look at services and at what it was possible to change. Whether that

was done formally, through a zero-based approach, is not the point. The point is that all our services are predominately driven by staff. It is staff who deliver everything, who make up the most important part of the budget, and who are the most important part of what we do. That means that it is not possible to make any sudden changes, because the deployment of staff resources, in any aspect of health and social care, depends on training, experience, effective teamwork, what is possible in different locations, and on how services are configured and organised. All those issues interact to make change a complex process.

When I worked in DFP, I heard, all the time, the plea from the Health Department that it needed a stable basis for three-year planning. That is what we have had for the past number of years, until now, when we are being asked to make a sudden additional reduction. The 2010-11 financial year looked challenging enough up to this point, but, as the Minister and others have explained, to then have the sudden imposition of a further reduction is very challenging.

We are very aware of the responsibility to re-examine options and to bring recommendations and analysis of suggested changes to the Minister. However, to effect those changes requires time, because it is only possible for services such as health and social care to evolve. It is impossible to make an abrupt change, because the staff will not be available in the right place at the right time, and an abrupt change would be very disconcerting to the people who depend on the services and who are used to a certain way of doing things. There is a need for consultation and engagement, and we are committed to having good processes to ensure engagement with patients, clients, service users, carers and the wider public, so that things can evolve in the right direction. That does mean change, and, sometimes, quite significant change, but such change has to be managed in a political context and be limited by what is physically possible. Change can only work if the staff are there and are able to do what they need to do.

Over the past few years, the delivery of the required efficiency savings has put the onus on the trusts to look very hard at how services are configured and organised and to look for savings that make services more efficient and which allow the front line to deliver what people need. That is being re-examined. There has been an immense amount of review and analysis of what can change. That has been very difficult, and it was difficult enough to find the 3·5% savings to complete the CSR efficiencies. Detailed work on that is still under consideration by the Minister.

Mr McDevitt:

I reiterate my party's absolute commitment to the protection of those programmes which target the most vulnerable; the young, the old and those who suffer from key clinical conditions that deserve and require ongoing support. However, with great respect, the question was not answered. Either we will achieve zero-based budgeting in this final year of the CSR period, or we will not. If we are getting there, the Committee will, at least, get a signal that the culture has shifted and that we are now seeking efficiency, not just over a three- or five-year cycle, but year-on-year.

This is an unfortunate question to have to ask. I would much prefer to ask a more strategic question about an overall series of plans or options that would be available to support the Minister in the Assembly in the weeks ahead. However, we cannot do that because you have not brought us the information.

Can I ask another question? Why are we seeing no progress or new thinking in regard to departmental or trust policy on merit payments for consultants or doctors? As I understand it, we are not seeing any such thing; if I am wrong, I apologise.

Dr McCormick:

The merit payment system is a part of the consultant's contract. It is administered locally in Northern Ireland, and there is some discussion of the quantum involved, but it is part of how the UK-wide system works. The payments are always under review, but they are part of how we ensure and reward excellence. We can review that matter, but it is important to keep it in perspective.

Mr McDevitt:

I have spent the past three years running a company in the private sector that was people-centred, as most of you will know. It required absolutely that we invested in excellence and kept our best people. However, I am acutely aware that, in order to work within a budget, we must worry not only about what is coming in but about costs and what we are spending. If the Department says that there are elements of cost in the health budget that are fixed because of a UK agreement, and we do not analyse or consider them at a regional level, that is an issue.

I want the best doctors to practise in this region; but I want them to do so on the understanding

that they are part of a process and system that is from this region. I do not want them to practise here because they can get a UK deal to work in Belfast.

The Minister of Health, Social Services and Public Safety:
If we break parity, those doctors will go to the UK. We are a part of the UK; we get £19 billion from the Treasury each year —

Mr McDevitt:
With the greatest respect, Minister, health is devolved to us.

The Minister of Health, Social Services and Public Safety:
You talk of high-level strategic finance.

Mr McDevitt:
I am talking about individual contracts for consultants.

The Minister of Health, Social Services and Public Safety:
You are talking about a very wide range of moneys. You were in business. If you do not have enough money in the business, it does not matter how zero-rated you make your budget or what merit principles you put in; if you do not have enough money to fund the activity, you do not fund it. We have a national pay deal for about 90% of our staff. A deal is a deal: that is the other thing you learn in business. You must stick to the deal. That has a resonance for issues under discussion in a place to which I must go shortly.

The Acting Chairperson:
You did not make the deal, though.

The Minister of Health, Social Services and Public Safety:
No. I did not.

Mr McDevitt:
My point is that is that we should make the deal —

The Minister of Health, Social Services and Public Safety:
I understand that you are talking about parity of pay with the UK. That is not the way to go. You want to take money from Health Service staff here, and I understand that. Our staff pay budget amounts to around 70% of the costs, so, you suggest that we should whack the staff. Our staff can do better if they move to England or to the Irish Republic. However, they stay with us, and we want to hold onto them.

I am not prepared to break a national pay deal. A deal is a deal. If you make a pay deal with the British Medical Association (BMA), the Royal College of Nursing (RCN) or UNISON, there are swings and roundabouts on such national deals. Ultimately, however, we do an awful lot better by being a part of that national pot than we would if we were separate and had regional pay. That is why we do that deal. An employer must stick to that deal, and that is what I intend to do. A deal is a deal.

With regard to making ourselves more efficient, there are no tricks involved. We can talk about zero-based accounting and merit wars, and so on, and we are looking at introducing incentives. However, there are no clever tricks or ruses that one can pull out of the hat that can make a budget that is £600 million light suddenly do the job.

In addition, we had to face the loss of £32 million for our half of the swine flu costs, and I had to pay that £32 million out of the health budget to cover those costs. I got £32 million from others, but I paid out £32 million. That is a cut. In addition, I am still waiting for the first £20 million of available resources that was promised in the budget settlement that I made.

I will give an example of the way in which our efficiencies and productivity are going up. When I came into the Department almost three years ago, around 43% of its drugs budget was for generic drugs; that figure is now around 60%. We have a steady growth. We are making an approximate 4% per annum change and, so far, that has netted us around £40 million on the prescribing side. We are now looking hard at the procurement side and at drug tariffs and formularies.

We are searching constantly for ways to be more efficient. We have reduced the hospital trusts from 18 to five; we have reduced the four health boards to one; we have established the Public Health Agency; we have gone to assured services with one organisation practising

economies of scale. When I see a way of making the Health Service more efficient, I do it, and when I see an opportunity to save costs, I take it. There are always opportunities. However, the bottom line is that I must provide health and social care for the population in Northern Ireland. That service must have quality and it must be safe, and that is always uppermost in my mind and in the minds the staff that provide that quality service.

When people run down the Health Service they run down the people who work in it: the doctors, nurses, child protection officers and allied health professions. Try running a hospital without cleaners or porters. Those people are all part of the team that provides the service; they are key to providing a safe, quality service, and they must get the support that they deserve. When you make a deal on wages, you stick to it. There will be new opportunities and new negotiations in due course, and I do not know whether they will involve the BMA, the staff side or the RCN. We will have discussions and do another deal, and we will stick to it.

Mrs McGill:
The Minister covered several points. I welcome the fact that he said that it was important to be here at this stage. I share his view that it is important to be here today. The Committee Clerk phoned me this morning to check whether the Committee would have a quorum, and I travelled the 75 miles from west Tyrone to hear what the Minister and his officials had to say. I am the only member here from west Tyrone, and I will not take up the Minister's time unnecessarily. As the Acting Chairperson, Mr McDevitt and John McCallister said, we do not have all the detail.

Along with the Minister, I want to put on record my appreciation for the staff of the Health Service, who deliver a service in very difficult circumstances. The Minister has outlined a very grim picture. You talked about social workers, carers and those in society who are most vulnerable. I also want to put on record that, last night, I received a call from parents who were extremely concerned about their daughter, and I phoned the family and childcare services in Omagh on their behalf this morning. I told the parents that I was attending this meeting today. The current situation in health is extremely difficult.

I am not clear on a point that you made in your briefing about the "historical lack of funding". Given all the money that comes here from the British Treasury, and without going into any detail or analysis of what is managed and what is not, are we getting enough to run this place? That is an unsophisticated way of putting it, but do we get enough to pay for the Health Service? I heard

you say that “a deal is a deal” when it comes to paying staff. Is there enough money to honour that deal? You asked for support in lobbying. Should we lobby here on how money could be tweaked and shifted around, or should we lobby for money at a different level?

I understand that the Minister has to leave shortly, but I wish to record my appreciation for the staff who work in extremely difficult circumstances in the Health Service.

The Minister of Health, Social Services and Public Safety:
As far as the Budget is concerned, this year’s block grant is about £19 billion. Half of that money is managed, and the other half is unmanaged. The unmanaged money funds the inescapable requirements: pensions, unemployment benefit, sickness benefit, and so on, which are paid automatically and directly.

This year, the Assembly has discretion over a Budget of about £9 billion. Health receives 43% of that, which means that 57% goes elsewhere. I suggest that we scrutinise where that money goes. In comparison with the UK, there are substantial overspends in several areas of government activity. I will not go into that, because it is not my job. I am here to manage the Health Service, not DFP. Some Assembly Members may assert that the health budget amounts to more than half of the total Budget, but it amounts to only 43% and, therefore, some 57% of the Budget remains available.

When money is tight, which it is, and it will become still tighter, one must stick to what is important. We must look after health, education and housing. Those are the areas that are inescapable, and a strong argument exists for ring-fencing those budgets. However, other areas of expenditure that are not crucial to life should be examined. We should assess, address and prioritise the need. There will be some things that we would like to do but will be unable to do. Every housewife who goes shopping would like to buy this, that and the other, but she buys what she can afford, and that depends on the amount of money in her purse. That is the approach that we must adopt too.

In answer to whether there is enough money to pay for the Health Service, the answer is yes. Let me give you an example. I discuss the budget with the trusts’ chief executives, who all tell me how tough the situation is. Sean Holland heads up social services, and I want to bring him in on the subject of the health budget. Sean is in a similar position to Michael McBride, Martin

Bradley and others in the Department who are trying to protect their budgets and struggling to cope. Sean will talk about child protection, children's services and vulnerable adults, which are important areas for all of us, and he will describe the many challenges that he faces.

Mr Sean Holland (Department of Health, Social Services and Public Safety): I wish to mention a couple of issues that I know are of concern to members, because I have spoken about them before the Committee previously: unallocated cases in child protection work and family support. As regards the latter, I am pleased to say that the Committee welcomed the Families Matter strategy when I presented it. What I wish to say links in with what Michael McBride said about early intervention and prevention. He was talking about healthcare, but the same is true of child protection services.

We can help families who are struggling at an early stage, and we can help parents to do what they want to do. The vast majority of parents want to bring up their children as best they can, but sometimes they need help to do that. However, if family difficulties are not addressed, they can become acute. When that happens, it requires a radical intervention on our part.

The Minister talked about service developments. To date, we have targeted a significant number of the service developments at increasing the level of family support for upstream and prevention work. In child protection services, we introduced service developments to have an impact on reducing the number of unallocated cases, about which the Committee, quite rightly, challenged me at a previous meeting.

It is important that the Committee set the issue of unallocated cases against a background of 30% underfunding for our services when compared with England. That is not our figure; DFP, in conjunction with OFMDFM and the Northern Ireland Commissioner for Children and Young People (NICCY) provided that. In December 2009, the number of unallocated cases was down to 797, which represents a 43% reduction compared with June 2009, when the Committee challenged me vigorously about those cases. If we have to pull back the money for service development, I am confident that the number of unallocated cases will rise, and with that rise comes a significant risk. We try to manage the risk as well as we can, but, if the number of unallocated cases increases, it is unfortunate, but inevitable, that the risk of a tragedy lurking among those cases will increase.

If we have to withdraw the other development moneys, we will have to focus on our statutory duties: the extremely difficult child protection work that involves taking children into care when they have already been abused, neglected or damaged. Such damage lasts a lifetime. The family support money, which we have earmarked for development, is used to ensure that we intervene before that damage is done. However, that is not a statutory requirement on the Department; we do that because it is the right thing to do. We must fulfil our statutory obligations. If we have to cut the development money, that is where I will have to go to look at saving money.

The Acting Chairperson:
Although only four members are present, some still wish to contribute further. I am conscious of the time, and the next set of witnesses is waiting, so I ask that questions and answers be concise.

Mrs McGill:
Thank you for allowing me to ask another question, Chair, and I thank the Minister for his response.

Sean, the last time that you were here, we discussed the issue of vulnerable children, and specifically the McElhill and McGovern case. You said that the Minister had announced that Henry Toner would return to the Western Trust.

Mr Holland:
I have a meeting scheduled with Henry Toner tomorrow morning to finalise the terms of reference.

Mrs McGill:
Has he been to the Western Trust yet?

Mr Holland:
No, we expect that he will conduct the fieldwork in February.

The Minister of Health, Social Services and Public Safety:
I understand that we are all pressed for time. You asked whether the Northern Ireland block grant is adequate. That is a question for Andrew McCormick to answer. As members know, he spent many years in DFP and, through his negotiations with the Treasury, is well aware of whether the

money is sufficient.

The Acting Chairperson:
The expression "poacher turned gamekeeper" springs to mind.

Dr McCormick:
I had better look at what is in my bag, because I am not doing very well.

The Treasury certainly believes that there is enough money and that Northern Ireland is well funded. Capital expenditure is higher in Northern Ireland, and that is why — as far as I am concerned — the issue was always one of considering the relative need. I can speak only in a health context, but the detailed work that DFP carried out over many years clearly reinforces the Minister's points.

John Appleby recommended that capital expenditure for health needed to rise by 4·3% a year in real terms for many years. In doing so, he made it clear that that would cause a problem for DFP and that it would place a significant pressure on other budgets. He recognised that DFP and the Treasury would have to deal with that issue. The judgements on what is needed are matters for DFP.

If the objective of today's session is to inform the evidence that the Committee will present to the Minister of Finance and Personnel and his Committee, that point must be strongly made. They must consider carefully whether there is enough money in the system. Our answer is clear: there is definitely not enough money, and evidence exists of major inadequacies. If we were to analyse our budgets and compare the need for expenditure with the amount available on any basis — whether it be zero-based, incremental or in some other way — we would come up with the same answer. Underfunding is a major problem that requires serious examination. A debate on that issue is required at DFP level, but it is up to that Department, not us, to judge what to do about the Treasury.

Mr McCallister:
Sean, your comments worry me greatly, because we all agree that early intervention is vital.

My question is addressed to the Minister and Andrew McCormick. We all know that money

will be extremely tight after the current CSR period. How did we get into such a mess so early? The Minister spoke of the parity principle in national pay deals. If we were to break that parity, would there be a danger of a knock-on effect? Might parity in the benefit system be endangered?

The Minister of Health, Social Services and Public Safety:
Once we start breaking the parity relationships, we do not know where that will end. As far as I am concerned, a deal is a deal. Our top consultants in Belfast could double their pay by moving to England or the Irish Republic and quadruple their pay by going to the States. However, they choose to stay with us because of the support that we give them.

That applies to all our staff. A particular job in Belfast should merit the same rate of pay as that same job in Glasgow, Cardiff or Southampton. That is the deal. We are all one country, and that is the national pay deal. I would be most reluctant to stir the situation by playing around with those relationships. That applies not only to staff and medics, but to nursing staff and those working in children's services. People who want to make a lot of money or be well rewarded, do not necessarily seek a job in some areas of the Health Service. I have studied some of the rates of pay. Conall talked about regionalising pay, but the existing rates of pay are not overly generous.

Mr McDevitt:
I wish to take the Minister up on that last point. I could not agree more with him. That is why it would be helpful for the Committee to understand what agreements are up for renewal, what the nature of those agreements are, whether they are national or regional, who are the competent authorities in the agreements, and whether the unions are UK-wide or have a regional aspect to their authority.

I hope to join my SDLP colleagues in supporting you, Minister, on the Floor of the Assembly against a DUP proposal to send people in, over your head, to seek efficiencies in your Department. Many members of the Committee share that aim. To do that, and to support all you good gentlemen in the great work that you do, we need to have all the relevant information, but we do not. That is where the relationship between the Committee and the Department will falter.

The Minister of Health, Social Services and Public Safety:
For three years, we have spewed out a ceaseless stream of information. That starts formally with Assembly questions and moves through FOI enquiries, statements, debates, conversations, the

provision of evidence, and so forth. Members of my staff attend virtually every Committee meeting. Today, members are hearing from staff, and, on other days, you hear from trust representatives. I do not know what other information you want.

If a service is not properly funded and money has to be taken away from it, its level of activity will diminish. Members want to know whether the cuts will fall mainly on mental health, learning disability, services for the elderly, children's services or cancer research — all of those options are unacceptable.

There is a proposal to send the performance and efficiency delivery unit (PEDU) into my Department. PEDU is a little outlet down in DFP that comprises three men and a dog. Anything that they do is, in fact, done by hired consultants. PEDU wants to come in because it has no other work to do. Everyone is full of clever tricks, but, no matter how efficient the Health Service becomes, it will never be enough. Everyone must accept that and acknowledge the fact that the Assembly does not provide enough money to fund health and social services. That leads to insufficient activity, which, in turn, results in unmet need. We must all put our hands up in that respect.

The Acting Chairperson:
Further to the DFP statement, have you or your Department developed any proposals on the invest to save fund? If so, will you provide information on that?

Mr Donaghy:
We are in the process of developing those proposals, but they are not finalised. We have yet to make our submission to the Committee.

The Acting Chairperson:
I am sure that we could have them in draft form.

The Minister of Health, Social Services and Public Safety:
Yes, I will provide a draft to the Committee. The last consideration of efficiency savings was as part of the Appleby report four or five years ago. That report came up with a number of recommendations, and the key recommendation was made in respect of DFP. That is the one recommendation whose implementation we await, but DFP has refused to implement it. When

DFP starts to act on its own advice, I will listen. If DFP wants to look for efficiencies, it should look in DFP.

The Acting Chairperson:

We cannot make any decisions today, because we do not have the required quorum to do so. Minister, I thank you and your team for coming.

I will finish with two points. The Chief Medical Officer talked about the problems that people with rheumatoid arthritis faced in 2005. His comments were a bit disingenuous, because, at that time, the National Institute for Health and Clinical Excellence (NICE) had responsibility for that issue. I was on the Committee for Health, Social Services and Public Safety at the time. We must be careful not to take NICE's advice at one stage and ignore it at other stages. The Chief Medical Officer said that the issue was to do with money; in fact, NICE had proposed that more tests on rheumatoid arthritis were required. My second point is that parity with England on civil servants' pay has been broken.

Dr McBride:

I did not wish to mislead the Committee or be disingenuous in my response. NICE guidance applied in Northern Ireland from May 2006, and it is a statement of fact that, in 2005, we had waiting times —

The Acting Chairperson:

The Department had no control over that. It had to follow the NICE guideline.

The Minister of Health, Social Services and Public Safety:

We followed the guideline. We do not question the advice but take it when we are able to do so, which is dependent on resources. On the second issue, as you are aware, another Minister deals with Civil Service pay.

The Chairperson:

Yes, but parity with pay in England was broken. I know that you are under pressure and that other things are happening in the Building that are outside our control, so I appreciate the fact that you took the time to come here today. Thank you.