Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Revised Programme of Expenditure 2010-11

27 May 2010

NORTHERN IRELAND ASSEMBLY

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COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Revised Programme of Expenditure 2010-11

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Thomas Buchanan
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Mr John McCallister
Mrs Claire McGill

Witnesses:
Mr Sean Donaghy)
Mr Sean Holland)
Dr Michael McBride) Department of Health, Social Services and Public Safety
Dr Andrew McCormick)
Mr Dean Sullivan)
Ms Diane Taylor)

The Chairperson (Mr Wells):

You are all very welcome. Obviously, this is an extremely important session, so I am pleased that just about everyone at a senior level in the Department of Health, Social Services and Public Safety (DHSSPS) is here.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): Thank you for the opportunity to attend and to take further the evidence on the financial plan for 2010-11. I apologise for the fact that the papers were not with the Committee for Health, Social Services and Public Safety earlier. We wanted to ensure that the documents were concise but contained enough detail. I hope that we can expand on the contents and provide further details as the Committee requires.

The process was difficult and took a considerable time because it was important to find the right balance. It is not our intention to make the matter more difficult or scarier than it needs to be. It would have been easier to take large amounts of money out of certain services and devise a financial plan on that basis, but that would have been irresponsible. The Minister of Health, Social Services and Public Safety spent much time working with us and taking advice from wider sectors, including the Health and Social Care Board and the Public Health Agency as they prepared the draft commissioning plan for 2010-11. We sought to achieve a good balance between setting tough but realistic targets for efficiency savings, thereby securing at least some sustained resources for some service developments. There are still significant service developments in the outcome that has been decided, but they are less than we had hoped and planned for.

We had to examine each aspect of the budget in great detail to establish the best combination of outcomes and decisions. There are at least four or five dimensions for that decision-making process and finding the final point of decision took some time. The Minister invested much effort and concern, pushing to secure as good an outcome as possible. There are significant difficulties, but there are also significant sustained opportunities.

The Health Service can climb this mountain; we can deal with the issues that lie ahead. The service will rise to the challenge and continue to deliver high-quality services for the people of Northern Ireland. Ten million pounds a day will still be spent on the services provided by the Health and Social Care Board and the Public Health Agency. The total budget is large, so many good things will continue to happen. The situation needs to be seen in perspective and in context.

I want to explain how the main figures come together and to draw out the contents of annex 1 to the Minister's letter of 27 May 2010. That annex draws together the main financial components. Sean Donaghy will expand on that if necessary. We were faced with the challenge

of finding £105 million of a recurrent reduction arising from the Executive's Budget decisions, which were finally confirmed only on 15 April 2010. Until that time, the Minister was still seeking a better position. However, the decision was taken, and we have had to work out the best way to deal with those pressures.

In addition, increases in demand for services are greater than had been anticipated, which means that costs are arising in what are fundamentally demand-led services. We have to respond to demand. There is a contract with the citizen to provide the best quality of health and social care that we can, and we cannot say no. We have to meet the demand, which has risen at a higher level than anticipated. One key element was demand on the elective side. We have sought to secure acceptable waiting list targets over the past number of years, which proved quite difficult in the 2009-2010 financial year. I will return to that when the full details are available.

The Minister had to make considered choices about what level of investment was appropriate. Over the past number of years, we spent much money on independent sector activity in a genuine effort to reduce and contain waiting times. This year, there is a deliberate decision to try to minimise expenditure in the independent sector but sustain reasonable waiting times. In some specialties across the trusts, that is not as good as we want it to be, but we have to secure the best that is possible in the context. Dean will cover the details of that, but the Minister decided that it was necessary to provide significant resources.

Paragraph 2 of annex 1 draws together the figures. The issues that we faced, including the need to deliver on the efficiency programme that the Executive and the Minister decided in 2008, meant that we had to identify sources of funds of some £285 million. We have had to find resources by a range of means to meet those costs. Paragraph 3 draws out the sources that we applied and that the Minister settled on. It is about trying to find the right balance in four or five dimensions to work out the best combination of decisions. Any one of those could be varied or be flexed in various ways.

There are any number of possible outcomes, but the Minister judged this to be the best one available. It tries to find a balance and secure sustained delivery of some of the most important developments, including aspects of mental health and learning disability, and acute services. We have also been realistic about what efficiencies can be secured, because trusts and the wider services face increased demand. We must be realistic about what is possible and ensure that the

workforce is available to provide the services that are needed. It has been difficult and complex to find that balance.

We also continue to set challenging and demanding targets for reductions in prescribing costs. Northern Ireland has had an issue in that regard for many years, but a team in the Department and across the service has done well and is making progress. The decisions that the Minister announced this week involve further and even more demanding targets to secure better efficiencies from that source. Paragraph 3 seeks to draw that out.

We have also provided more detail on service developments. Annex 2 breaks down into more detail what the new plans still provide for and enable the service to do. We also sought to draw out the most important examples of what can no longer be sustained. Those are measures that were planned, announced and that the Minister was determined to do but that are no longer possible because of the reductions that we face. Those are outlined in different paragraphs under the heading "We are not". We are not investing as much as we would like, and we are not able to provide in certain areas. We are open for questions on the complexity of the provisions and the important set of decisions that the Minister has taken.

All that is consistent with the revised priorities for action. The targets and analysis that are set out in that document reflect the detailed decisions that the Minister has taken. All of that is available.

Annex 3 is about workforce control. An important element of the savings is the £40 million from employer organisations to secure efficiency savings from the workforce, which is by far the largest component of health and social care expenditure. Annex 3 explains the means that are used to ensure that we have the right people in the right place at the right time while still securing significant savings. That is a major challenge, but it is necessary. Diane can help with any detailed points on that issue.

I must correct myself: I thought that there was a summary of the priorities for action. I gather that that has not been sent, but members have the main document. Everything is consistent with the documents that were provided on Tuesday 25 May 2010. They expand on the earlier papers.

In broad terms, that is how the numbers come together. We have a balanced financial plan

that still delivers the best that is possible for health and social care in Northern Ireland. It provides some significant new developments. We are trying to do the best with what we have, which means being clear and firm on a range of efficiency measures, not least on the administrative side. That continues with the delivery of the savings that are required under the review of public administration (RPA). All that is being pursued as vigorously as possible, and the Minister is determined to ensure that the front line is protected, services are delivered and that we do the very best that we can.

The Chairperson:

As you know, at the meeting that the Deputy Chairperson and I had with the Minister, Diane Taylor talked us through the complexities of how the £40 million staffing savings were to be achieved. I want to ask her to give other Committee members the benefit of that knowledge because some of us may not even have reached annex 3. I will allow Diane to gather her thoughts.

There seems to be no mention of the £21 million capital budget saving. Last Thursday, John Cole briefed the Committee at the Downshire Hospital, and the issue was raised repeatedly today in relation to places such as Tyrone. There is no indication of where we stand with capital for the current financial year or the projects that have been shelved, delayed or are going ahead. Why is there no explanation?

Dr McCormick:

There is further ongoing work on those details. I am sure that John and Stephen explained that the planning of a capital programme must be addressed in relation to a series of years. Some matters always need to be done regularly, but project management requires a view of budgets across the years. Considerable uncertainty exists about what is realistic to plan for 2011-12 and beyond. It would be irresponsible to commit to projects that start in the next few months when the budget could disappear next year, and we may not be able to complete them. There is still a complexity about the decisions over several years.

In the next few weeks, we will seek to resolve at least some decisions that will allow projects to proceed. There will still be fewer projects than planned because the Executive decided that the health capital budget should be reduced by £21 million in 2010-11. Even in committing and allocating what remains for 2010-11, we must keep an eye on the longer term. The Omagh

project has complex and difficult issues, which, when it starts, will take several years to deliver. We must be sure that the budget is there not only for the year in which building starts but for future years. Otherwise, we will end up with a half-built project, which is not acceptable.

The situation is more difficult, and there is more to come. I am sure that John and his colleagues will be ready to come to the Committee when further decisions are taken and details are available. However, that is not available yet.

Ms Diane Taylor (Department of Health, Social Services and Public Safety):
I will talk members through annex 3, after which I am happy to answer any questions about the workforce. Under the original comprehensive spending review (CSR) efficiency programme, the Minister outlined the type of plans that needed to put in place. The workforce is a huge part of the expenditure of the health and social care sector, so plans were in place to reduce the number of posts and also to make investments in posts.

At the end of March 2010, I measured that activity and considered what had happened with posts being reduced in the service and what investment had gone back into the service. This year, a further push is required because we are not as far advanced as we expected to be. It was determined, therefore, that each organisation has to find efficiencies of 2% of payroll cost in 2010-11.

Trusts will be expected to continue with their plans to realign and reform services. The amount of money that is spent on agency staff, overtime and locum staff will have to be considered carefully because those types of activities command much expenditure.

Every post to be filled, whether new or replacement, will have to be scrutinised. That means that, in the natural turnover of some 7% each year in the health and social care sector, trusts will examine all posts to see whether they are critical to service delivery and a safe and effective service before they are filled. That further alignment is necessary to balance the workforce with the service that needs to be delivered. There is a service, and the workforce has to be there to deliver it. However, there will be service change and reform to make savings.

Redeployment and retraining will continue. An individual may no longer deliver in a post because that post is disappearing, but that does not necessarily mean that that person goes. He or

she could be redeployed and retrained to deliver a service elsewhere. The Minister has stated that a compulsory redundancy programme will not be used to achieve the current 2% level of required savings. If a further level of savings is imposed, we will need to consider what exactly is needed.

The Chairperson:

That is not new, of course. Those efficiency savings in staffing costs were expected under the CSR.

Ms Taylor:

That is correct.

The Chairperson:

It is implicit in what you say that some trusts did not come up to the mark in what was expected of them. Which trusts have been making the proper savings, and which trusts are behind with their savings?

Ms Taylor:

All the trusts have made huge efforts and considerable progress. However, all trusts have more to do. I could not pick out a particular trust and say that it has done well and another trust has not. They all have more work to do.

The Chairperson:

If they have not been able to reach the targets under less stringent financial regimes, what confidence do you have in them to deliver in the coming financial year with everything that is about to be heaped on them?

Ms Taylor:

This year is slightly different in that that process will be closely managed by the Health and Social Care Board. A programme board is being set up, headed up by John Compton, the chief executive of the Health and Social Care Board, and it will monitor constantly. Monthly progress reports will detail the trusts' positions on achieving their targets, and the Minister will receive quarterly reports.

Dr McCormick:

Trusts have had to face rising demands, and efficiency delivery targets have been set. That would have been sustainable, but increases in demand kicked in over and above what was expected, especially in the past year. That made the challenge all the more difficult, and some trusts found that to be a major challenge in the 2009-2010 financial year, as you know from debates on emerging trust deficits.

Those issues were largely resolved during the 2009-2010 financial year by a range of means. The challenge is even more intense this year, hence the rigorous process that Diane described, which will ensure that progress is sustained. Demand increased by 20% over the past two years, which demonstrates the challenges that the Health Service has faced.

The Chairperson:

I can see what you are trying to do in the thrust of what is happening. You could simply have chopped services completely, but instead you decided to try to skim off expenditure in a number of areas. That will require a great deal of monitoring and administration. Further pressure will be put on John Compton, his board and the trusts. Will trying to achieve so much fine slicing not overwhelm the trusts? Is it deliverable?

Dr McCormick:

We believe that it is deliverable. It is the best available way forward. Once the draft commissioning plan has been considered by the boards of the Health and Social Care Board and the Public Health Agency today and by the Minister, and after the Committee discusses it next week, the next step will be to engage in more detailed planning at trust level. The trusts have made certain assumptions up to this point. The detailed confirmation of their budgets and the challenges that they will face are still to come, but we are confident that the process is manageable and that the task is achievable. It is the responsibility of any public body to deliver at the level of resources that is set by the Assembly. That is the way that it should be, and the trusts will do everything possible to secure the combination of financial balance, high-quality and safe services and the best possible performance. They are clear that that is the mission. I am confident that it can be delivered.

The Chairperson:

The layout of the 2010-11 financial plan and the annexes is helpful. Let us look at one example

under the heading "Mental Health":

"We are not … Securing as many contracts with voluntary sector organisations for advocacy".

Why are the savings not indicated down the right-hand side of the document? I assume that the voluntary organisations concerned have no idea of the hit that they are going to take. Many of those organisations depend on departmental funding. If you are going to save £100,000, we can be fairly relaxed. However, if you are going to save £5 million, that will create a crisis for those organisations. Why does the document not include a budget line outlining the savings that will be made against each item?

Dr McCormick:

It would have been misleading to attempt to do that in fine detail, because the position will depend on the detail of the commissioning plan, which has yet to be adopted, and on what happens in the trusts. We sought to give an overview. Under each heading, there is a statement of the total that is still being provided and the amounts that we have had to save, compared with previous plans. We will try to provide more detail if the Committee so wishes. To have attempted to provide fine details would have been impractical.

The Chairperson:

Therefore, in mental-health services, you know that you are saving £9·6 million**.**

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

I will make one additional point about the example that you chose. What we have said that we will not do in that area does not represent a cut from current activity. It is not about withdrawing money from the voluntary sector. It is money that we had hoped to spend in new contracts with the voluntary sector that we do not now plan to spend. It is not about laying people off or stopping a service that we currently buy. We are not going to able to spend in areas in which we hoped to develop a service further.

The Chairperson:

We are one sixth into the financial year. Have certain voluntary organisations been led to believe that money was coming and will now find that it is not? Will they have to change their plans accordingly? Is it money that they never knew that they were going to receive in the first place?

Mr Holland:

It may have been money that they had hoped would come, but we have not entered into a contract with those organisations. We have not started the business of purchasing from them. We have plans across a range of areas for service developments. On Tuesday, as you will recall, the Minister referenced the service development moneys as being an area in which we are not going to spend as much as we had hoped. A number of work areas that we will not be doing are ones that will not begin rather than a cutting back of existing services.

The Chairperson:

Under the heading "Public Health", annex 2 states that, in 2010-11, the Department is not:

"Investing in smoking cessation focused on manual workers and pregnant women".

I thought that that was a public service agreement (PSA) target that you could not get out of.

Dr Michael McBride (Department of Health, Social Services and Public Safety):

We have set ourselves a challenging target on reducing the prevalence of smoking in adults to 22% across Northern Ireland and to 28% among manual workers. In the past number of years, we invested significantly in smoking cessation services, and we took targeted actions. The review of the published tobacco action plan has three priority areas: pregnant women, young people and, particularly, manual workers.

We will invest in those areas, but, as Sean Holland said, we will not specifically target the investment in those services to the same extent as we would have wished. The PSA target and the priorities for action target, which is also set out in the draft commissioning plan, will be more difficult to achieve, but we are still committed to achieving them. It is not that we are not investing, but we are not investing to the same level.

The Chairperson:

There are two references to reductions in respite care, yet, at Westminster, that area was specifically ring-fenced for an increase. On the mainland, it is proposed that some of the money that will be saved from the suspension of the child trust fund, around £8 million this year, will go towards increasing respite care. It appears that, rather than increasing funding for respite care, the devolved Assembly will freeze or reduce it.

Dr McCormick:

The new Government's announcement this week indicates a policy of not taking a share of reductions from the Health Service. It is entirely up to the Assembly and the Executive to take a similar view if they wish.

The Chairperson:

We are at variance with London on that issue. The Government see the need to enhance respite care, and it is a burning issue for MLAs. People who look after someone who has a long-term illness or mental-health difficulties say that increased resources for respite care are desperately needed. London recognised that and ring-fenced and increased funding, yet, in two separate parts of annex 2, the Department says that it is using the issue to reduce funding.

Dr McCormick:

If the Health Service in Northern Ireland were treated on the same funding basis as health and social care in England, we could do what you suggest. The decision that makes that difficult has been taken by the Executive.

Mrs O'Neill:

I welcome the investment plans that are set out in the overview of the financial plan, but I will pick up on a few points. I want to raise eight or nine issues. We will not discuss all of them now, but I will write to you about them after the meeting.

Diane, thank you for your explanation about workforce control. Who is involved in the scrutiny of vacant posts? Are unions involved? Members and others often hear that staff are under pressure, and there are genuine concerns that that process will impact further on their workload. Are the unions involved in the process at every level across the trusts?

Ms Taylor:

It is a joined-up exercise at trust level, which includes finance, human resources and service managers. That joined-up process is to ensure that the direction in which the trusts wish to move is correct. At this stage, the unions are not involved in the process, although the issue was raised with the unions recently, and the Minister wants to examine that and progress it.

Mrs O'Neill:

A previous target was a reduction in the number of children in care by 12% by 2011, but that is not one of the new targets.

Mr Holland:

That has nothing to do with the financial difficulties that we face. We were concerned by the possibility that children were in care who did not need to be in care. We discovered that when older children were leaving care rather than when they were entering care. That was shortly after I came into post. Although the policy objective remains the same — no one is in care who does not need to be — there was a concern that the previous target could have had unintentional consequences: people could have tried to stop those who should be in care from entering care. The concern was whether we reviewed people to ensure that they were not drifting in care and that we actively evaluated whether there was a possibility for them to be at home for a trial period and no longer on a care order. That is why we changed that target.

Mrs O'Neill:

Annex 2 states that the Department is still "largely protecting" the area of child protection. The word "largely" is very generous. What is slipping?

Mr Holland:

The Minister recognised that, within the constraints that he faced, children's social services were historically underfunded. We have said on several occasions in Committee that they were approximately 30% underfunded compared with the best in England, despite significant rises in demand. In the past five years, there has been a 30% increase in the number of referrals to children's social services and a 76% increase in the number of children on the child protection register. At the beginning of this CSR period, the Minister chose to prioritise that area for investment. At this point, he has decided that we will try to consolidate those gains so that we do not lose them.

Although we are not doing as much as we would have like to do, it is more about the volume of work that we will still undertake. For example, we are investing in family support packages. It is important that we try, where possible, to maintain children with their families and that we support families who, although struggling, are fundamentally able to keep their children with them. We had hoped to increase the number to 3,500 family support packages, but there will be

3,000 new packages. That is an example of an area in which we are not doing as much as we would like. However, we are staying with the gains that we made: £1·3 million has been invested in preventative services, and some £8 million has been invested over the CSR period in strengthening gateway and family intervention teams. All those areas are being consolidated; we are not touching them.

However, we need to be very clear that there will be pressure on child protection services. It goes back to Diane and Andrew's earlier point: we are trying not to cut services wholesale. Nothing that we do in health and social care is unimportant or easily dispensed with. We are applying pressure across the board. If the staffing situation is controlled, there will be pressure everywhere.

That said, we have very low vacancy rates in children's social services; they run at about 0·5%. Diane will correct me, but I think that that is particularly low. That means that, even in the context of putting pressure on the staffing bill, child protection services should not be significantly affected.

Mrs O'Neill:

That is to be welcomed. How will the physical disability strategy be affected? Annex 2 states that expenditure in that area is:

"some £3·8m less than had been planned".

Will that have a negative impact on progressing the physical disability strategy?

Mr Holland:

That means that we will not do as much as we would like to do. There is an investment of some £1 million on physical disability. We are also increasing the number of respite packages, so there will be additional respite for physical disability.

Like most areas, we are trying to make improvements across the board. However, they will be slower than, or perhaps not as extensive as, we would have liked.

Mrs O'Neill:

Increasing the capacity of radiotherapy services by 600 patients by March 2011, critical care and neonatal transport do not appear in the revised priorities for action.

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

There were plans to expand critical care capacity in 2010-11, but that is no longer possible because of the funding issues that we explained at length. We will still progress the issue of neonatal transport.

Dr McBride:

There were proposals to expand radiotherapy capacity at the Belfast Health and Social Care Trust's cancer centre, and we had to pause that expansion. We were going to put an additional linear accelerator into the facility, and that will not now happen in-year. However, we plan to develop a new satellite radiotherapy centre at Altnagelvin Area Hospital, subject to proposals and agreement of the business case by the Department of Finance and Personnel (DFP). All that is critically dependent on capital moneys and the revenue consequences to run the service. There have been consequences, which we will seek to minimise where possible.

Mrs O'Neill:

We were told about the predicted demand for the service, which will put it under pressure.

Dr McBride:

There is a range of pressures on services. There are some 8,500 cancer diagnoses each year. That will increase significantly because of our ageing population and advances in the treatment of cancers. People are surviving longer, and there will be more and greater demand for radiotherapy services as part of their treatment. We must keep pace with that demand, but we need to do so within the available resources. We simply cannot do some things in the current financial year, but increasing radiotherapy capacity is a long-term objective for the Department.

Mrs O'Neill:

May I ask one more question?

The Chairperson:

Yes. Those are short, sharp, relevant questions, and an example of how to get maximum impact.

Mrs O'Neill:

In the revised priorities for action, there is some enhancement of service development for eating

disorders, although it also states a need for:

"at least a 10% reduction in extra contractual referrals".

I assume that that means sending people to England for treatment. What will be put in place here for those who need treatment?

Dr McBride:

There is a reduction in the funding that we wished to invest in eating disorder services. That area has required additional investment and has been discussed in Committee. We are investing moneys this year but certainly not of the scale that we initially intended.

Our approach is to enlarge community-based teams gradually, and we have a target to reduce by 10% the number of extra-contractual referrals to other parts of the UK, because we recognise the fact that it is distressing for individuals and for their relatives to seek such care outside Northern Ireland. For the time being, given the level of investment that we can make in the service, we will make slow but steady progress, but certainly not the level of progress that we wanted to make.

Mr Sullivan:

The aim is to reduce by 10% the number of extra-contractual referrals in 2010-11. That is a movement of funds. We would have been spending that money in any case to pay for patients to go across the water to England or elsewhere. That money is simply being used in a different way to try to put in place appropriate arrangements in Northern Ireland to allow patients to be cared for locally.

Mrs O'Neill:

I have some other questions, but I can put them in writing.

The Chairperson:

We are moving on quite quickly, so we may have time to come back to those questions.

Mr Easton:

Andrew, you said that the Executive have asked for a £105 million reduction. Is that right? Is that a slight reduction on the original figure?

Dr McCormick:

That is the recurrent side. If the capital is added in, there is an additional £21 million. The £105 million includes the £92 million that was our share of the main Budget reduction that was announced in January 2010. There is also the issue of the way in which the Department of Finance and Personnel handled the additional swine flu resources in the February monitoring round. When the Department declared a reduced requirement, DFP took the view that, because that money was owed to Departments, we were required to give it back not in 2009-2010, as is usual, but in 2010-11. Hence, there was a further reduction to our 2010-11 budget. That is where the £105 million comes from. That was an unusual development, but it is what the Executive decided to do.

Mr Easton:

You said that there will be no forced redundancies, but you intend to save £40 million by not replacing non-essential staff who leave or by allowing staff to take early retirement. Given that figure of £40 million, you must have a perception of the number of staff who will not be coming back, even though they will not be forced out. Roughly how many will there be?

Ms Taylor:

The figure equates to some 1,300 whole-time equivalent staff. However, it is unhelpful to think of it as 1,300 people because a proportion of the figure equates to activities, such as overtime, and bank, agency and locum use. We use a calculation to convert that activity into the whole-time equivalent. There will be posts in that total, but it is better to think of them simply as posts rather than as jobs that are filled by 1,300 people. A reduction in posts and activity will combine with turnover to make savings of £40 million.

Mr Easton:

Annex 2 refers to anti-TNF drugs for rheumatoid arthritis. You had planned to reduce the waiting time to 21 weeks, which would have been excellent. However, that will be put back because of the cuts. Could you consider increasing the pace of the use of generic drugs? Would that not give you an opportunity to reduce waiting times more quickly? Many people are crippled with arthritis, and it is not good that they have to wait nine months for drugs.

Mr Sullivan:

I think that everyone would agree with you. I have met a few of the patients. They used to have

to wait for years for treatment, and even a nine month-wait is still far too long. The plan had been to bring that waiting time down to 21 weeks, which would have been consistent with the PSA target that had been set for March 2011. Unfortunately, those drugs are very expensive, and that reduction simply is not possible given the funding that is now available for 2010-11.

In parallel, as part of our efforts to come up with a balanced budget for 2010-11, plans are being made to increase further, to 64%, the use of generic prescribing. Therefore, we have already banked that option in the context of the wider picture. Unfortunately, because of the issues that I raised, it is impossible — at this time, anyway — to pull the waiting time down below nine months. We will hold it at nine months in 2010-11.

The Chairperson:

The cuts will bite when constituents come to us about waiting times. I have seen one young lady's life being totally revolutionised by those drugs. I know that they are expensive. We will have to be ready for people saying that they were expecting treatment in six weeks but they now have to wait for nine months.

Mr Sullivan:

That is the reality of the situation. There is this idea that there is a bottomless pit of cash and, if only we look in a different place, we could find more. The reality is that patients will wait longer for life-transforming treatments than otherwise would have been the case. That is one impact of the £100 million in cuts.

Mr Easton:

I will ask one more question. I have a few others that I will pass on to the Committee Clerk.

The amount of money that is spent on agency and bank staff is astronomical, and I would have liked a proportional reduction. How drastic will your proposed cuts in the use of agency and bank staff be? A happy balance must be struck between a reduction in the use of agency staff and ensuring that regular staff can cope. Will your proposed cuts have a severe impact on the agencies' ability to keep their staff in work?

Ms Taylor:

You are absolutely right. Agency staff will always be needed, and bank staff will be needed to

some extent, because any large organisation needs the flexibility to use agencies to make changes and service reforms. There will always be some agency use. I am not saying that a reduction in that activity will have no impact, because it will. However, that will be managed alongside service reform to get the balance right. It will be a huge challenge for trusts this year. I cannot tell you that we will drop £20 million from our agency costs because it is not as defined as that. However, the cuts will work their way through the system as service reform rolls out throughout the year.

Mr Easton:

Do you have a projected percentage that you hope to achieve?

Ms Taylor:

No percentage has been defined at present. An amount will come from agency, bank, locum, overtime, and so forth. Plans have been put in place, but not in that level of detail.

Mr McCallister:

Andrew, what rise in demand have you factored in for this year? Have you set it at 9% or 10%? I ask because, on Tuesday, the Minister repeatedly made the point that there has been a 20% rise in demand over the past two years. You reiterated that. Are you relying on the service standing still for that time?

Dr McCormick:

By no means. Some additional resources were always planned to take account of demographic increases. The major costs, for example, of additional elderly care packages are relatively predictable. When the Minister made his decisions, he protected that increase. However, we also took a wider approach to projecting demand for acute services, children's services and so on.

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

This year, the headroom for coping with further expansions in demand is limited. The rises in acute sector demand over the past three years are not typical. The rises in elective services, in particular, are not typical. In fact, it could be said that we have been the victim of our own success. The sheer scale of the reduction in waiting times stimulated increased demand for those services, and we simply could not plan for or afford a continuing year-to-year increase of that level. We have not made an assumption of further increases in demand for elective services. If

there were a significant increase, we would struggle, and the waiting time targets, albeit their not being as good as we would have liked, would no longer be attainable. However, we have no reason to believe that there will be increases in demand. The rises were relatively atypical over that three-year period, and we believe that they were a reaction to services being more accessible than they had been for many years.

Mr McCallister:

They were almost catching up from problems in previous years.

Mr Donaghy:

Yes, they were.

Dr McCormick:

I emphasise: that is exactly what the Minister sought to do to deal with major issues in the configuration and leadership of health and social care. He wants to shift towards a prevention- and early-intervention-based strategy. The establishment of the Public Health Agency and other initiatives are designed to move in that direction. Further work is under consideration that will move us towards better demand management. We must try to reach that point. When the financial situation is tough, it is all the more important that we hold to those vital strategic directions to ensure that issues are not dealt with through treatment if is possible to get upstream and prevent, for example, a disease evolving and to manage problems more proactively. That is central to strategy, which is why the Minister made the structural changes. We need to maintain that impetus. The Minister balanced the budget in this way because he is determined that the public health agenda is protected and continues to have a significant emphasis.

Mr McCallister:

I agree entirely with Andrew, and I have consistently supported that strategy. You refer to what we might call the "Wanless imperative", which involves investing in upstream prevention and early detection. You will not now be able to do that as you would have liked.

Dr McCormick:

We will not be able to do as much of that as we want to, but we must continue to do as much as possible.

Mr McCallister:

When do you hope to see some payback? The improvement of public health is probably a long-term goal, and there will not be payback in one financial year. A return may be seen in five or 10 years' time.

Dr McBride:

That is a pertinent comment, and, as Andrew said, it is the fundamental premise of the review of public administration. As the Minister said, it is designed to ensure that the improvement of public health is at the heart of all government and departmental policy. The Public Health Agency will drive that agenda forward.

Although some advances in public health that relate to prevention are medium to long term, there has been significant progress even since the publication of the Investing for Health strategy in 2002. We are reviewing that strategy with a view to publishing a new Investing for Health strategy in 2012. We have made significant progress and will continue to invest in that area. However, we have not made as much progress as we would have liked to and will not be able to invest as much as we want to.

The issue of demand is important. Priority 3 of the Minister's priorities for action identify specific actions about pathway management; hospital discharges; driving down unplanned admissions through investment in long-term condition management; and palliative care so that more people can choose to die in their own home rather than in hospital. Priority 4 includes a range of issues about helping older people to live independently. We invested in packages to support that, we have an assessment tool, and we previously discussed that with the Committee.

We want to ensure that we manage health and social care and keep people well in different ways. As I said on Tuesday, healthcare does not stand still, and it has never done so. We want to ensure that we have the right configuration of health and social care services and provision based on population need so that we have a Health Service that is fit for purpose. That work begins now and will continue next year. It will always be continuing.

Mr Holland:

Some of the benefits of preventative work can be realised quickly. I mentioned earlier the 30% increase in referrals to children's services and the 76% increase in the child protection register.

Simultaneously, we invested in preventative services for children and front-line child protection services.

We have not seen a commensurate increase in the number of children coming into care, which has more or less stayed steady. By putting services into supporting families at an earlier stage, we are maintaining children at home and stopping them from coming into care. I emphasise: children will be brought into care if necessary. We know that the long-term outcomes for those children will last for 40, 50, 60 to 70 years. There are benefits to be gained from early prevention that will last a lifetime.

Mr McCallister:

The financial plan is fairly ambitious. If trusts struggled to meet targets in the past financial year and have deficits, how will they cope in this financial year? Some of the issues that Diane talked about, such as staffing costs and management to ensure that the trusts can deliver, are very ambitious given the problems that we ran into last year with individual trusts, the Northern Health and Social Care Trust being the most obvious.

Dr McCormick:

As was said earlier, it is about ensuring that we have firm, clear, focused management arrangements and keeping the range of different projects that need to be undertaken in each organisation under continuous review. It is clearly a difficult challenge, but it is obtainable. Through discussions with the Health and Social Care Board and the trusts, we know that they are aware of the scale of the challenge that faces them and that it is possible to meet that challenge. We will keep it under close review. We will monitor the financial figures, payroll and the nature of what is being delivered through the change programmes, and we will work that through very carefully.

Mr Donaghy:

Trusts struggled in the first two years. It is not the case that trusts failed to deliver efficiencies to date; when we reviewed the plans for 2010-11, we knew that we simply could not bank on that to be the case. Our plans envisaged that trusts would realise savings of some £96 million in 2010-11. It would have been foolish for us to plan to spend that money when we were concerned about how deliverable our plans were. That is where the pressure came from.

The agenda is very challenging for trusts. We took a formal decision to reduce the scale of that challenge for trusts by some 1% in 2010-11. We can still demonstrate where we are meeting our 9% CSR savings. We have had to change tack. We referred earlier to the increased scale of challenge in prescribing budget reductions into next year.

One outcome of the scale of the pressures that we have been talking about for the past half-hour is that we reached the conclusion — reluctantly, because it means making sacrifices — that we could not rely on that scale of savings being achieved by trusts in the face of meeting those mounting demand pressures. Based on our understanding of our current pay bill across the health and social care sector, we took a careful and balanced view of what is deliverable. Diane spoke about that and about the mechanisms that we intend to use to ensure that that is delivered and that, in the process of delivering it, we do not damage services. It is a fine balance that will require a huge amount of attention.

In addition, we have set a target that trusts must begin to assemble larger-scale plans for changes in services, which will be subject to proper dialogue and debate during this year. The areas that we will begin to consider will be set out in the commissioning plan. Towards the end of this year, we will begin to see some changes that will help us to recover some ground. Otherwise, the inexorable demand for services, which is caused by the fact that the population is growing all the time and that Northern Ireland has the fastest-growing elderly population in the UK, cannot be met. We must continue to change just to survive. We think that that is deliverable in 2010-11.

Mr Gallagher:

I am concerned about unequal treatment across the trusts in certain aspects of the delivery of healthcare, particularly care in the community and the rehabilitation of hospital patients. That has been going on for a long time, and I am concerned that that will increase because of the pressures on the trusts. I take some encouragement from what you said about regularly monitoring what the trusts are spending.

Cuts will affect stroke sufferers, and there are already concerns that treatment and support for stroke sufferers is delivered on a postcode basis. The treatment of dementia sufferers also demands a high level of care, and it looks as though funding for that area will be cut.

Dr McCormick:

Our system commits to a fair distribution of resources through the capitation arrangements. We have to be extremely careful when we get into difficult issues of trust management, because overspend by trusts or unresolved deficits challenge a defence of that distribution. Therefore, we have to manage that carefully and balance the obligation to provide a fair distribution of resources across the region with ensuring that that does not result in a disruption or a severe change. We have had to face some of those dilemmas with the Northern Trust and the Belfast Trust in the 2009-2010 financial year.

The fundamental commitment stands that the formula is in place as the commissioning system develops, and we are clear that resources are going to local commissioning groups on the basis of that formula. That system needs to mature to ensure that local commissioners are empowered with an increasingly devolved budget to ensure fair treatment.

Mr Donaghy:

I will speak about the financial side briefly, because I am sure that members are anxious to hear about the details of the services. We use a capitation formula, which involves a sophisticated process that has been around for at least 15 years. The population of Northern Ireland is measured, and demand is stratified by age band. We carefully examine the needs profile of all people in Northern Ireland to come up with a target share of the overall DHSSPS budget. That is the guiding factor that tells us how much money to make available for each population.

There will always be variations in how those services are delivered, because they are delivered by human beings. That is why it is important that we support and challenge trusts and hold them to account. The money that goes out is subject to a strict set of fair play rules. Thereafter, it is about how well people can use those resources and how effectively they can marshal them. Different areas need a different fit; Belfast does not have the same needs as Derry. We have to ensure that that fit is managed as well as possible. That is what the new system is about — local commissioning.

Dr McBride:

I know about the personal experiences of members in relation to strokes. John and Tommy were present at the consultation on the implementation of the stroke strategy. We met many people who had been affected by strokes, which are a major cause of mortality in Northern Ireland.

Many people are left severely disabled because of the impact of a stroke. Given that order of priority, we invested £3 million over the past two years in the development of stroke services.

When we were determining priorities for the development of the service frameworks, which set specific standards for the commissioning of services in Northern Ireland, the first one that we took forward was the cardiovascular service framework, which contains specific standards for the prevention of strokes, managing blood pressure and treatment of groups at increased risk.

In annex 2, we state that we will invest some £1·7 million additional moneys in stroke services in 2010-11. That is less than we had intended, and we will not be able to invest in some of the other priority areas that Tommy mentioned, particularly in relation to rehabilitation and support in the community. We had planned for investment in those areas in 2010-11, but we will not be able to take them forward. There are other broader elements of the cardiovascular service framework that will have to be introduced on a longer timescale. The difficult decisions that we have made will have an impact.

Mr Gallagher:

Sean Holland spoke about children's services, and we had a discussion about that. He talked about holding our ground or staying with our gains. However, I am also concerned about the increase in the number of referrals to do with the physical and sexual abuse of children. Against the background of that increase, are you confident that the gateway arrangements will be robust enough to deal with the apparent increase in demand for Health Service responses?

Mr Holland:

You are right, Tommy. There is pressure there, and we should not be surprised by that. There are a few statistics that are worth bearing in mind when we consider the situation of children. One hundred thousand children in Northern Ireland are living in poverty, and 40,000 are living in families with substance misuse problems. The statistic that I find most distressing is that there are at least 11,000 children living with daily domestic violence in Northern Ireland. Inevitably, that translates into pressure on children's services.

I believe that we are holding the line. We operate a service — I anticipate that we will continue to offer it — that I would describe as being within the parameters of safety for the coming year. However, there will be difficulties. I mentioned that issue in another context

during the Committee meeting on Tuesday. We made significant progress on unallocated cases. In June 2009, we had reached almost 1,400 unallocated cases, and by January 2010, as a result of urging by the Committee, we had brought that down to just over 700 cases. Those numbers are starting to rise, and as pressure on teams increases, the numbers are likely to continue to rise. We have to keep a constant eye on the situation, and we have to assess risk constantly. I emphasise: those unallocated cases are risk-managed in that we screen them, but there will be pressure.

The difficulty is that there is no such thing in child protection as running a completely safe service. Child protection is not like that; it is constantly about balancing and managing risks. However, we will be able to operate within the parameters of what is professionally acceptable this coming year.

Dementia is another area in which we are not doing nearly as much as we would have liked. Over the CSR period, we will invest £0·6 million to provide an extra 1,200 respite places for dementia. That is not as much as is needed or as we wanted; we would have been much more comfortable with an investment of £1 million in that area.

John made a point about whether we are anticipating the rise in overall demand; demographic money, which we talked about on Tuesday, is one part of that. A significant proportion of the demographic money that we set aside will be for domiciliary care packages. Inevitably, many of those will support people who have a family member who suffers from dementia to stay at home.

The Chairperson:

We now unleash the trio from West Tyrone. I suspect that I know what issues will be raised.

Mr Buchanan:

I will be very civilised this time, Chairperson. There is planned expenditure on staff training and development, so obviously there will be a reduction in that. Is there any danger that that could affect front-line services? Will it affect the staff who are involved in the 2% reduction in payroll costs, who may require retraining?

Ms Taylor:

Central money is available from the Department for retraining, which would be post-registration training for nurses, postgraduate doctors and associated health professionals. Much of the

infrastructure for training is in place. Organisations will then have to identify the training that is needed through providers such as the universities, in service or wherever it is provided. There is a reduction in staff training and development but not to the extent that it would affect a retraining and redeployment programme.

Mr Buchanan:

Will it affect front-line services?

Ms Taylor:

No, it will not.

Mr Buchanan:

That is fair enough. You will not be able to buy any additional intensive care beds. We all know that they are a vital component in delivering front-line services. What happens if the demand increases beyond the current bed capacity? How would you deal with such a situation?

Dr McBride:

We invested significantly in additional intensive care capacity over the past number of years. Indeed, our well-developed plans were brought into stark reality when we were planning and preparing for the potential impacts on the service of the H1N1 virus. We had plans in place to double physical capacity for adult, paediatric and neonatal intensive care if that were required. In the initial phases, that involves converting high-dependency beds into intensive care beds and ensuring that staffing levels are appropriate. In all our trusts, we have clear escalation plans, and if there were an immediate pressure on beds, we use the skills of staff who have critical care experience and training expertise in maintaining airways and managing patients who are being ventilated. We also have plans to expand critical care capacity where that is required.

We have not been able to put additional bed capacity into our current capacity, despite having planned to do so. We will have to use, and flex between, high-dependency beds and critical care beds to maximise the demand and meet the demand on services. It is expensive to put an additional critical care bed in place because it is not simply about ventilators; it is about trained staff. The Health Service is provided by trained people for people, and we do not have the resource in 2010-11 for that additional critical care capacity. Obviously, we will need to come back to that because there is an increasing demand for critical care. The population is ageing, and

demographic change, which the Committee discussed earlier, is likely to continue.

Mr Buchanan:

Should the trusts not be able to meet the requirements as laid down? Some members mentioned that issue. Trusts tell us that they are currently stretched to the limit.

You said that you will implement firm and clear management arrangements. However, monitoring is one thing but meeting demand is another. If the trusts say that they are not able to meet the demand, rather than a monitoring role, is there a hands-on role — for want of a better phrase — for the Health and Social Care Board to assist the trusts to meet the demand?

Dr McCormick:

In such a situation, that is the direction in which we would need to go. The trusts that are in most difficulty have a much closer relationship with the Health and Social Care Board, in management terms, than they would normally have. We have had to instigate that special arrangement to ensure strong reinforcement of the control mechanism. The situation is difficult and delicate, but the organisations are responding positively.

We will keep the situation under close review and will keep a careful eye on what emerges as each month passes. Starting from July, when we will have the first indications of the pattern of spend in the organisations, we will examine the situation. I am not talking about passively monitoring the level of expenditure; we will examine the progress and the milestones achieved towards the types of changes that are required to secure savings. Those all need to be managed as projects, and, if those projects are not meeting their milestones, more detailed intervention and oversight from the Health and Social Care Board will be required. The board is willing to do that.

Mrs McGill:

I want to return to a point that the Chairperson raised about respite, particularly for elderly carers. The Minister reiterates his commitment to the most vulnerable people in society. In my area, we feel that there has been a historic underfunding in provision for local people with learning disabilities and mental-health issues. That has been accepted. Will the funding for those two groups be protected and increased, given that inequality?

An issue that is raised repeatedly is that there is not enough respite for elderly carers or,

indeed, for carers generally. I am getting conflicting messages from annex 2. For example, it states that you are still:

"Providing 25 more packages for respite than last year — one package benefits many families".

However, it also states that you are not:

"Investing as heavily in the above developments … as we had originally planned".

Despite that, two days ago the Minister said — I hope that I remember this correctly — that there would be increased respite for elderly carers. I welcomed that at the time. What is the position on that issue? I am asking because the issue is raised repeatedly by different groups and by those carers who do not receive respite care.

Mr Holland, the last time that you were in Committee, I asked you whether there were enough social workers to ensure continuity of provision. If a social worker is assigned to someone, will he or she remain with that person, or are the pressures on the service so heavy and so challenging that they prevent that from being the case. Is funding for that service protected?

Mr Donaghy said that the situation is challenging for the trusts. However, it is exceptionally challenging for the staff; I want to discuss workforce issues later.

Mr Holland:

You rightly mention learning disability. An increasing number of people with a learning disability are looked after by older carers. We are investing in additional learning disability respite services. You referenced the contradiction in annex 2, where in one place it states that we are investing in additional services, but in another place it states that we are not. We are investing in respite for learning disability but not to the extent that we would like to. Total investment over the CSR period is £3·2 million.

You also referenced an additional 25 packages for respite, and, to re-emphasise your point, 25 packages are not 25 cases. The way in which we present a respite package is a complicated business. We recognise the fact that respite can be a person staying somewhere overnight to give someone else a break. There is also purposeful respite, because we are trying to make respite more flexible. Assistance could be about taking someone out for a day, perhaps shopping or to the local leisure centre. Therefore, we talk about packages rather than simply single respite places.

We can provide you with clarification in writing, but the investment is not nearly as much as we would like. Originally, the plan was to invest probably a further £2·8 million or £2·9 million in respite packages. We are doing more than we have done before, but we would like to do an awful lot more. That is also the case for demographic money for domiciliary care for older people, which was mentioned earlier.

I will move on to the position on social work and social work staffing. I will be happy to follow up with a written answer to give you a more detailed breakdown of the related issues. However, our social work workforce is different to the UK's in a number of ways. Our social work workforce tends to be far less mobile than that in the rest of the UK, and we use fewer agency staff than other parts of the UK. The vast majority of social workers who work in Northern Ireland were trained in Northern Ireland, and we probably have the best social work courses in the entire UK. All of that means that our social work workforce has greater stability and consistency than that in other parts of the UK.

Our highest turnover levels come in the child protection teams, where there is pressure. From memory, I think that the highest turnover levels are in the Belfast Trust and the Southern Trust; I will clarify that for you in writing. However, we run a very low level of vacancies in our social work workforce, which means that there is not as much turnover as you might expect. That is not to say that our workforce is not under a huge amount of stress: they are under an incredible amount of stress.

Today's Committee hearing is focused on money, but there are actions that are not primarily about money that can be taken. In the coming weeks, we will bring forward Northern Ireland's first social work strategy. It will be about supporting social workers on the front line by ensuring that they are trained better, that they receive the supervision that they need, that they are properly equipped with risk management training and that they have the necessary governance arrangements. We developed that policy in close partnership with the British Association of Social Workers, UNISON and the Northern Ireland Public Service Alliance (NIPSA). We worked hard with staff to come up with a strategy that will support them in their difficult jobs. I am happy to come and talk to you about the strategy in more detail before its launch.

Mrs McGill:

Diane said, probably an hour ago, that every single post will be scrutinised. I am worried that

some way will be found of not replacing people who leave posts. Front-line staff will, therefore, be under increasing pressure and will have more paperwork. Some staff might not even get to the so-called front line, and that will cause a build-up. I take it that all those matters are in the mix, that they are being considered and that there is a way to deal with them. I have heard that nurses, in particular, are virtually passing themselves in hospital corridors. Are you saying that that situation will improve next year and beyond? How will that be managed?

Ms Taylor:

Trusts must carefully manage that in a joined-up way. It is based on clinical decisions, such as the safety of patients and the number of staff who are required to cover rotas. All those factors that are in the mix must be taken into consideration. As I said, trusts do that in a joined-up way. Trade unions expressed their desire to be involved in that process as well, and that needs to be examined. If a post goes in an area that is critical to service provision, it will be replaced because it must be, and a decision will be taken on that. However, changes to, or the realignment of, services may mean that a number of posts in a certain area will no longer exist, but similar posts will exist in another place instead.

Mrs McGill:

Does that apply to every single post? I look at Health Service job advertisements, and I noticed recently that the post of director of performance and service improvement, which has a salary of around £106,000, was advertised. I take it that that post is critical to performance, but for which service? I will, of course, raise the issue with John Compton next week. If you do not have an answer, I am content enough to hear from you at a later stage.

The Business Services Organisation advertised for a conduct officer, and I was just wondering what a conduct officer does. However, I will also raise that with John Compton at a later stage.

The Chairperson:

Do you wish to add anything to that? Most of that was self-explanatory.

Dr McCormick:

The director of performance and service improvement leads work to ensure that the service delivers to the set standards of performance in the Minister's priorities for action. The director will work in a challenge role as well as a supportive role. That key leadership role in the Health

and Social Care Board fell vacant recently.

The Chairperson:

What does a conduct officer do?

Dr McCormick:

I do not have the details of that.

Mrs McGill:

The salary for a conduct officer is around £34,000.

Dr McCormick:

I am sure that David Bingham, the chief executive of the Business Services Organisation, will help with that.

Mrs McGill:

Does the Department scrutinise all those posts? Do the Minister and the Department sign off on them?

Dr McCormick:

They sign off on senior posts. However, junior posts are the responsibility of each organisation, which are all under a strict regime. We are still working out the delivery of savings under the review of public administration. The number of administration posts is down significantly compared with three or four years ago. We are still determined to deliver the savings targets. We are working to ensure that we have the right size of management and structure. The Minister is strong on scrutinising and challenging that. We assure the Committee that we will do everything possible to achieve that.

Mrs McGill:

We repeatedly emphasise the difficulties that front-line staff experience. It is important that every post is subject to the same type of scrutiny, assessment and evaluation.

The Chairperson:

We have been going for an hour and a half. The good news is that I have to leave at 6.00 pm, so

that gives you an indication of how much more time we have.

Dr Deeny:

We could do with a conduct officer here sometimes. Diane and gentlemen, thank you for your attendance. Annex 2 states that the Department is:

"Seeking to ensure patients have timely access to outpatients (9 weeks)".

That is a bit misleading, because it applies only to first appointments. There is a huge issue with review appointments, and that is coming through from speaking to people at GP surgeries all the time. People are waiting for review appointments for lengthy periods. You may have heard that someone rang Frank Mitchell's radio show on U105 to talk about review appointments at the school of dentistry. I hear that from many of my colleagues, and that is the problem with targets that focus on the first appointment.

It is good that psychotherapy services, priority 6.3, remain. Those services are part of general mental health and are important for us in primary care. The target is still to have a 13-week maximum waiting time for defined psychotherapy services. What does "defined" mean in that context? Can you assure me that the target for people to be referred and be seen within 13 weeks will be consistent across Northern Ireland?

Mr Sullivan:

I agree with your point about review appointments. I do not attribute that delay to a negative side effect of targets per se. In an ideal world, there would not be targets for anything and matters would be dealt with to the standard that one would expect. I would not accept from any organisation the excuse that delays are an acceptable side effect of targets.

The fact is that patients are waiting for far too long for review appointments, and this year, for the first time, there is a specific target in the Minister's revised priorities for action to tackle that. In the context of the financial environment that we have been discussing, it will not be possible to resolve that fully during 2010-11, but there is a clear target for it to be sorted out by March 2012. A range of responses to that, including working with local commissioners and primary care practitioners, will consider the issue, and there is more than one way of going after it. It is not just about patients being seen by a consultant; different models are available in hospitals and in primary care. I know that, with different hats on, we will talk about what those models might look like.

If you had asked me a year ago what defined psychotherapy services meant, I am sure that I would have been able to tell you. I apologise that I am unable to remember what it means, but I will reply to you in writing, Kieran. I assure you that a detailed definitions document sits behind all the priorities in the revised priorities for action. That document sets out exactly what we mean and where the clock starts and stops in that 13-week period for each of the targets that are pulled together by the Health and Social Care Board and agreed by the Department and others. It will ensure a consistent approach on measurement across Northern Ireland.

Dr Deeny:

I will try to save you money by talking about three areas. I have an interest in generic prescribing, and I know that GPs in primary care are committed to it. My practice is heading towards using 60% generic medicine. You said that an amount was already banked. How much does the use of generic medicine save each year? If the Department were to incentivise GPs in primary care by showing them that investment is being made in community care, they would be up for the job, and there is no reason why we cannot save the Department money in that way. If we were to reach 64% use of generic medicine, how much money would we save?

Andrew, I take your point that you want to avoid capital investment if the funding is going to fall down in year 2 or year 3. Given our previous conversations and today's conversations, do you agree that, if the capital project in Omagh were one third of the price of that which was originally set down for Downe Hospital, it would be more likely that it could go ahead? We are not talking £190 million; we are talking £50 million to £60 million. That would content everybody; it is something to think about.

Since we are here to discuss our feelings openly and honestly, I must say that, when I talk to those who work in primary care and in the allied health professions, they ask me why we need five trusts and whether one health authority would suffice. I should declare an interest as a member of the Western Local Commissioning Group. We may have input from all areas on the commissioning of services, but the trusts are the providers. I ask whether we need five trusts because that is the question that is asked of me. I agree with other Committee members that there is inconsistency across the trusts in the provision of services; the Department should consider that.

Correct me if I am wrong, but it appears to me that the Southern Trust is taking the lead. Other trusts talk to it about stroke services, and people seem far happier with how those services are provided. If the Committee and the people of Northern Ireland see that standards of care vary among trusts, they will ask whether there should be one authority so that standards in all the trusts can be pulled up to the level of the Southern Trust — the best — to set the standard. Would that not save a great deal of money? We have a population of only 1·8 million people. That may be a radical suggestion, but I am curious to hear your views. People are worried about duplication and are increasingly questioning the inconsistency of standards of treatment across trusts.

Dr McCormick:

The model must take account of good organisational capacity; people must be able to manage organisations. Compared with organisations in other parts of the UK, ours are substantial; indeed, the Belfast Trust is much larger than most similar organisations elsewhere. That is an enormous management challenge, and we need to recognise the fact that integrated services for a community must be scaled proportionately and manageably.

The model that the Minister adopted in the review of public administration involves commissioning, and that gives us some choice in providers. In a small place such as Northern Ireland, that choice is not extensive, and it will never be an enormous feature; we are not remotely talking about the market-type model that the Labour Government introduced in England. However, to allow commissioners stronger influence over organisations, they should be able to commission services from the better rather than from the less successful provider. That should create an edge and provide pressure for improvement.

The objective is to secure the best for all, and commissioners should settle only for a satisfactory provision from any provider. Ensuring a strong commissioning function for which commissioners negotiate to secure the right services is the best way to iron out inconsistencies. However, it is complex. If it were possible simply to decree that everyone should do everything to a consistently high standard, it would have been done years ago. However, organisations are much more complex; there is far too much variation in human behaviour.

The model that we have enables us to lead change positively and to secure a sound basis for commissioning through consistent service frameworks; that is the way to go. A standard has been defined, and a way of proceeding has been worked through to find a pathway of care; that is how

commissioning is done. We want to reinforce those who are most successful and challenge those who are less successful to adopt good practice, secure high standards and raise the level for all on a fair basis. That is our intention. My experience makes me wary about creating larger organisations at this time.

Dr Deeny:

If the hospital in Omagh could save you £120 million, Andrew, would you not announce that?

Dr McCormick:

That is a matter for negotiation and consideration as the Minister considers the options. We face a new situation. The Minister said that he will deliver what was promised if the money was there. However, we must examine what is possible in the emerging situation. That is a helpful train of thought.

Mr Sullivan:

The generic prescribing rate is approximately 59%. The target is to increase that to 64% by March 2011. That is built into one of the figures in annex 1 at paragraph 3(iv):

"the delivery of additional efficiencies from family health services in particular pharmacy control (£46m)".

I do not have the precise figure for generic prescribing to hand, but I will write to you.

The Chairperson:

The Deputy Chairperson has a question about what are euphemistically called "enhancements".

Mrs O'Neill:

My question is about clinical excellence boards and bonuses. At a time of financial constraint, with people feeling that front-line services are being squeezed and nursing staff are under pressure, we read headlines of £11·6 million being paid out in bonuses to senior consultants. I cannot get my head around that. I cannot understand how that is possible. You said that bonuses were negotiated across England, Scotland and Wales, and here. However, it is unacceptable that bonuses of that level are being paid at a time of such financial constraint. Will you confirm that £11·6 million is paid out, and whether you term them "bonuses" or "clinical excellence awards"?

Ms Taylor:

The clinical excellence award scheme in Northern Ireland is worth £11 million. Of that, £6

million goes in higher awards that are made through the clinical excellence committee, and some £5 million is awarded on discretionary points by trusts locally. The scheme is to reward consultants for exceptional contributions to health and social care. Their terms and conditions make them eligible to apply to the schemes. There is a scheme in each of the four UK countries. They differ slightly, and the scheme in Northern Ireland is probably the least generous in the number of consultants who are eligible to receive awards according to the formula that we use.

The Cabinet Secretary for Health and Wellbeing in Scotland asked for a review of the clinical excellence scheme. She asked that of the Secretary of State for Health in England and of the devolved Administrations. Our Minister replied that we are willing to take part in that review. The direction in Scotland is about looking across all healthcare professions and seeing whether there is merit in awarding excellence across all professions. We have to see what comes out of that review, and it has not yet met.

Mrs O'Neill:

I am of the view that the scheme is for everyone or no one. Cleaning and nursing staff can be excellent in their jobs, so why award just a consultant? I welcome the review, and the Committee should be mindful of it.

I want to clarify one point with you, Diane: did you say that scrutiny of posts will be at every level in a trust?

Ms Taylor:

It will have to be examined through all occupational groups.

The Chairperson:

A chief executive post is coming up in September, so it will be interesting to see whether that is reviewed.

Are you still receiving the first £20 million in the monitoring round? Is that still part of your budget?

Dr McCormick:

That is still part of our budgetary assumption.

The Chairperson:

Where is that vis-à-vis the £113 million? Is the £20 million included in that?

Dr McCormick:

No, it is not. The £113 million was the reduction from the previous plans. The previous plans and the current plans continue to assume that we are committing money on the basis that the £20 million will be made available. Part of the reason for the reduction was to eliminate the overcommitment that had been built into the budgets from many years ago. That was removed and, all other things being equal, that should mean that there is more chance of savings being available, and, therefore, it should come more readily. However, the truth is that we now have to find a further £138 million reduction. All other things are definitely not equal, and we face a challenge.

The Minister made his position clear, which is that this outcome is deliverable and manageable without the need for compulsory redundancies at this stage. If we face a further reduction, there are much greater problems. I guess, following this week's events, that that £20 million is more vulnerable than we have assumed.

The Chairperson:

Are you still precluded from bidding on the monitoring rounds, apart from that? For instance, you cannot put in a bid in June for extra money. Part of the deal for the flexibility is that you do not receive any more than £20 million.

Dr McCormick:

That is correct.

The Chairperson:

I am trying to think of the issues that could come up and bite us. We already mentioned the anti-TNF drugs for rheumatoid arthritis, and I am certain that that will hit the headlines.

Take me through the impact on cancer services. Has there been any consultation with the cancer charities? Obviously, they have a partnership with you on the treatment of patients and their various campaigns. Where does cancer sit in all of this?

Dr McBride:

Cancer is a major priority because it is a major cause of morbidity and mortality. As you will be aware, we worked closely with a variety of cancer charities in the development of the cancer service framework, which was a process of engagement involving many of the cancer charities, patients and users of the service. That document has been consulted on and is presently with the Department. We will publish the service framework towards the autumn. There has been significant engagement, and they have been major partners in the development of the cancer service framework. Given the reduced funding for the cancer strategy that we published some time ago, there will be implications for the cancer service framework in relation to the timing and phasing of the introduction of some standards. We have not engaged formally or discussed the implications of the budget with the charities.

The Chairperson:

Are you assuming that a second round of swine flu will not arrive in the autumn? Are you analysing what is happening in the southern hemisphere? Is the issue dead? If it comes back, is there anything in the figures to deal with it?

Dr McCormick:

We are not ignoring swine flu. We continue to monitor and to keep in touch. There is no specific major provision for a further wave; that does not form part of the projections at this time, but we are keeping it under close review.

The Chairperson:

What will you do if swine flu comes back? Is there anything in the budget to cope with it?

Dr McCormick:

We are restocking.

Dr McBride:

The H1N1 virus has not gone away. We have been very fortunate to date. Despite the deaths in Northern Ireland, the 580 hospital admissions and people being admitted to intensive care, the impact was not as severe as it was first thought from the initial reports. We have been lucky because the virus has not mutated or changed to date. However, flu viruses are unpredictable,

and we are observing carefully what is happening in the southern hemisphere. We are still vaccinating people who are at risk or coming into at-risk groups — for example, people who have not taken up the opportunity of the vaccine to date or those who newly enter those groups. We are still offering the vaccine to pregnant women. We are still preparing and ensuring that people are protected against swine flu. However, with regard to there being room for manoeuvre if we were to have a further wave or if a more virulent strain arises, there is no financial provision in the figures. As the Minister said on Tuesday, what we would seek to do in those circumstances, as we did on this occasion, would be to bid back to DFP — as was in our budget settlement — for resources to meet particular pressures.

The Chairperson:

The reason why some questions are being repeated is because Tuesday's meeting with the Minister was held in private session. It is important to record that publicly. We are going well here. Productivity bonuses could be awarded to the Department today for all that it has done for us.

Trust budgets are also an issue. You should now be in a position to know whether the five or six trusts stayed within their budgets. Has any overhang accumulated in the trusts in 2009-2010?

Dr McCormick:

That is an important issue that will be made clear in the accounts for all the organisations and for the Department. Last autumn, when the situation was difficult in the Northern Trust and the Belfast Trust, the Minister recognised that the actions that those trusts would have to take to deliver their original budgets were not acceptable measures. Therefore, he agreed to make a special supplementary allocation at the end of the year for those two trusts: £19 million for the Northern Trust and £12 million for the Belfast Trust.

Those were accepted overspends, which then received a special allocation of resources to ensure that it was not necessary for the trusts to cut services by those amounts this year to balance them again. That would have been normal practice, but this was a major issue of management. A problem arose, but we are now determined, as part of the process that we are working through this year and into next year, to get those organisations into a stable financial position. That is part of what we have to do in a challenging financial context.

Those two organisations faced a combination of rising demand and difficulty in delivering savings, as Sean Donaghy mentioned earlier. That proved challenging and difficult, and we had to make the best judgement we could about the balance between corrective action and supplementary allocation. We have had to proceed with that. It is not satisfactory, and it has led to a more intensive control arrangement. That is why the interim management team in the Northern Trust — the acting chief executive and acting finance director — were set a specific challenge last autumn to begin to restore that organisation to financial stability. That is ongoing work, it is challenging, but we feel that we made the right decisions.

Mr Donaghy:

Across the £4·3 billion revenue budget for healthcare, the provisional underspend for health, which is yet to be confirmed, is £5·9 million — 0·01%. That gives members a feel for how tight the overall budget is for health and social care.

The Chairperson:

There is a £31 million deficit between two trusts, and now you are adding £113 million, the vast bulk of which will be borne by the trusts. It shows the stress that they will be under.

I am thinking about an issue that will haunt us: cardiac surgery. We are talking about a 26-week wait. Andrew Dougal from Northern Ireland Chest Heart and Stroke will feel very strongly about that. That is storing up trouble, because much could go wrong in that 26 weeks for the patient. How much will that decision save?

Mr Sullivan:

That decision was not taken lightly. We are in a zero sum game about everything that we discussed this afternoon. That could have been kept at 13 weeks. I will give members a feel for the costs using round numbers**.** Every cardiac procedure typically costs approximately £20,000 by the time all expenses are included. The Belfast Trust has the capacity to carry out 1,000 procedures a year. To have delivered even a 21-week wait this year, which is what we first worked towards — our considerations reached that level of granularity — would have required an additional 400 procedures to have been carried out outside the Northern Ireland Health Service. We settled on a maximum wait of 26 weeks, which will require some 300 additional procedures. The difference between those two figures amounts to approximately £2 million. The difference between a 26-week maximum wait and a 21-week maximum wait is 100 procedures, and an

additional 200 to 300 procedures would have been required to get the maximum wait down to anywhere near 13 weeks.

We have been in that place. A decision was taken by the Minister for the reasons that you mentioned: it would not have been appropriate for patients to have to wait the maximum 36 weeks that, unfortunately, has occurred in other specialties. That is why, uniquely, the average has settled at 26 weeks. Reducing that any further would have meant that it would have popped up elsewhere as a cost pressure. It is cold comfort to recall that, four or five years ago, patients had to wait for years for cardiac surgery. The waiting time is better than it was previously, but it is not as good as we would want it to be.

The Chairperson:
There are no further burning issues to be explored. I appreciate your honesty, particularly in respect of trust deficits. As far as I know, that is new information to us.

I hope that we are not back here in a few weeks' time to deal with another series of cuts, after the Chancellor's latest announcement on Monday. This session has been very helpful. It has been a long meeting; it is now 5.35 pm. I was only joking when I said that I had to leave at 6.00 pm, but it could well be that we will be leaving here at that time.

I thank you all for your co-operation.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):
Before the Committee takes a break, I thought that it would be helpful to say something about the information that we have provided. I am conscious that there is a great deal of material, and I thought that I should say a word about the context, so that the Committee can make the best possible use of its valuable time.

The first of two key events was the Minister's decision on the allocation of resources. That was initially discussed on Tuesday of this week, and we have provided further details on it. The Minister takes the important decisions and, contrary to the old joke, he decides what constitutes an important decision. He has set the priorities for action, which are detailed in one of the documents that the Committee received on Tuesday. We have provided a summary of that today. We have also provided an overview of the financial position. That details what projects will

continue, despite the reductions, and what it is now not possible to proceed with. The overview was put together in response to the request on Tuesday, and I hope that it is helpful.

All of that is expressed in the Minister's request to the Health and Social Care Board and the Public Health Agency to turn his decisions into a more detailed commissioning plan on which work continues. However, we have the draft commissioning plan that the board and the agency put before their respective boards at meetings today. As the commissioning plan will soon start to appear in the public domain and will attract some public comment, the Minister thought it important for the Committee to receive copies from the Department today.

I understand, however, that time has been set aside to discuss the plan next week. I gently suggest, therefore, that there is no need to read the long commissioning plan at this stage. If members want to raise any initial points at this stage, we will, naturally do our best to respond. However, our focus is on addressing the Minister's decisions, as set out in the summary paper on the financial allocations and in the summary of the priorities for action. I hope that that is helpful.

The Chairperson:

I am happy enough with what you recommend. However, for about the fifth week in a row, information that we requested has arrived on the day of the meeting. We had hoped to receive all of that documentation yesterday. As you know, there was a debacle as regards the documents that we should have received for that meeting on Tuesday. Previously, I served on the DRD Committee, and it was exceptionally rare for that to happen. You really must try to get the material to the Committee in time. Ideally, we should have received all the material last night to give us a chance to read it. .

That said, I accept your suggestion, and the Committee will now take a 15- minute break to read the material. At first glance, it will be extremely difficult to assimilate all the information within that time, because it is all over the place. You have arrived at a highly complex arrangement by which to make the savings. Some people expected that the loss of a particular service or services would save, for example, £15 million.

Dr McCormick:

My officials and I will do our best to answer questions and explain the context when we return.