Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Evidence Session with Departmental Officials on Northern Ireland Executive Budget 2010

21 October 2010

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mrs Mary Bradley
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Mr Sam Gardiner
Mr Paul Girvan
Ms Sue Ramsey

Witnesses:

Dr Andrew McCormick	)	
Ms Catherine Daly	)	Department of Health, Social Services and Public Safety
Mr Martin Bradley	)	
Ms Christine Smyth	)	

The Chairperson (Mr Wells):

None of the witnesses require much introduction. We have Dr Andrew McCormick, who is the permanent secretary in the Department and has been before us many times; Catherine Daly, who is the acting under secretary of resources and performance management; Martin Bradley, who is a

season-ticket holder to this Committee; and Christine Smyth. Have you been to the Committee before, Christine?

Ms Christine Smyth (Department of Health, Social Services and Public Safety):
No, I have not.

The Chairperson:
You are very welcome.

There is considerable media interest in this issue, and we will break at 3.30 pm to try to deal with some of the media questioning. You will have a fair idea of what is likely to come up this afternoon.

Mr Easton:
Can we get a list of the capital budget components?

The Chairperson:
That is a very good point. Does the £4·3 billion refer to the revenue and capital budgets?

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):
No, that is the revenue budget.

The Chairperson:
So, there is no flow chart for the capital spend.

Dr McCormick:
We can say a bit about that.

The Chairperson:
It does not look like there will be very much to flow, but it will be interesting to see what we will miss.

Dr McCormick:
This is a very challenging time to have this discussion, because we are still coming to terms with

and trying to understand the implications of yesterday's announcement. You said that this will probably be the most challenging period in the history of the Committee; it will also be a very challenging period for health and social care.

There are many uncertainties, and there are limits on what we can say today, because, although the position across the UK is now clear, there are some enormous decisions for the Executive and the Assembly to take. We will be glad to provide any evidence, information or analysis that we can to help to move that process forward.

It is worth highlighting some of the main points from yesterday; both fact and statement. The Chancellor said that he was fulfilling the promises that the coalition Government had made on the NHS. He said:

"The NHS is an intrinsic part of the fabric of our country. It is the embodiment of a fair society."

He said that health spending in England will rise each year over and above inflation and that:

"to govern is to choose, and we have chosen the national health service."

He went on to say:

"For health spending, as for other spending announcements, there will be consequential allocations for Scotland, Wales and Northern Ireland. The Barnett formula will be applied in the usual way, which means that the increase in health spending and the relative protection of education spending will feed through to the devolved resource budget. It means that all three nations will actually see cash rises in their budget, although rises below the rate of inflation."

The table in the Treasury document published yesterday shows that very clearly. It shows the real term cumulative growth or decline of the resource budgets of the main Departments, excluding depreciation. For the NHS, the table shows a rise over the four years of 1·3%.

The table shows the total declining by 8·3%. So, an 8·3% decline is the norm for all Departments across the water.

There is a 1·3% increase for the NHS in England. In Northern Ireland, there is a 6·9% decrease in real terms. That is a bit above the average, because the largest single factor that affects the Northern Ireland total is the Barnett consequential of the health allocation in England. The figures that affect the Barnett formula are heavily affected by the health settlement in England. So, the reason why the Northern Ireland settlement is at 6·9% in real terms and not 25%, as it is in the Department for Business, Innovation and Skills, 24%, as it is in the Foreign and Commonwealth Office, or 29%, as it is in the Department for Environment, Food and Rural

Affairs, is that the Government have protected the health budget in England. That is how the numbers work. The largest single factor driving the Barnett formula is the health settlement in England, which will get a 1·3% increase in real terms.

The Chancellor also mentioned the education budget, which will be reduced by 3·4%. That is not as big a reduction as in other Departments and is a bit better than had been expected. The spin going out at the weekend was that education had gained a little bit of ground.

The Government have provided Barnett consequentials for the substantial settlement for the Health Service in England, which is the biggest single factor affecting our allocation.

The Chancellor went on to say that there are still very significant challenges for the Health Service in England to improve quality and productivity. The chief executive of the NHS in England, Sir David Nicholson, wrote to the Health Service yesterday. Last year, he said that the NHS in England would likely have to make between £15 billion and £20 billion of savings through quality and productivity changes. So, even with real terms growth in its allocation, the NHS in England will have to deliver significantly on quality and productivity. That all shows what is happening in the wider context.

The Chancellor went on to say that there had been concern in local government about the financing of social care. The concern had been that social care, as part of the local government system in England, would face substantial reductions. Local government funding as a whole is going down by 14% in real terms. However, the Chancellor announced £2 billion additional funding for social care in England to protect the most vulnerable, recognising that they are moving towards what we have already; greater integration of health and social care. From talking to colleagues in the Department of Health over the past number of months, I know that they were very concerned about a significant reduction in the social care budget, because it would lead to people not getting the care that they need in their own homes and missing out on support, which would lead to more people needing to draw on the Health Service. The two are inextricably linked, which has been recognised materially in the settlement that was announced yesterday for local government in England, with £1 billion to flow through the NHS into social care and £1 billion extra through a grant to local government.

Those were very significant announcements. The decision on how to proceed in Northern

Ireland rests with the Executive and the Assembly. That is the essence of devolution. All that I have said so far has been to build a context.

What I have said is highly relevant, because lots of the decisions that are taken about how health services work depend on decisions taken at a national level. The main costs that we face are essentially determined across the UK. The pay contracts are four-country contracts, and many aspects of the guidance on clinical and social care practice are developed and worked out on a four-country basis as are what are seen as good standards of care by professionals. That is what the service aspires to offer. Over the whole life of the NHS, the state has been committed to providing what the patient and client need, when they need it, and free at the point of use. Those are clear principles of the NHS. The way in which that provision is worked out and afforded is largely established on a four-country basis. That means that the public here tend to expect the same kind of service and access to the same therapies, drugs and new developments as elsewhere. As medicine and social care evolves, there is an expectation that we will provide that. That is what the public have been led to expect. The question now is what will be decided by Northern Ireland? The timing of this discussion is really important in those terms.

We still have to await the outcome of the Executive's discussions tomorrow. However, there is clearly some way to go before we will have any clarity about the proposals that will be put in front of the Department for the Minister to consider. The range of outcomes that Sean Donaghy presented to the Committee when he was here previously indicated that the Executive were looking at a worst-case scenario based on what information DFP had asked us to provide about going down from a budget from £4·3 billion to around £3·9 billion and on the different requirements that DFP had placed on us on a pro rata basis. I think that Sean also explained that our best estimate of the cost of continuing to provide services in the way in which we currently do, based on projections of inflation, demand, demography and the cost of improvements, is around £5·4 billion. That is where the figure of £1·5 billion, which was quoted this week and was cited as a possible problem, came from. Obviously, on the basis of yesterday's announcement, the hope and expectation are that we will not face anything as deep and as low as £3·9 billion. Hopefully, that is worse than what the worst-case scenario will be. However, the decision is still awaited. Nothing is definite, because the Executive have not made a statement about the approach that they are going to take to the funding of health and social care.

Even in the best-case scenario — and this a little bit like what David Nicholson said — there

will be no question that the Health Service will need to deliver additional improvements in quality and productivity to balance whatever budget it ends up with. If the Executive do not decide to give substantial protection to health and social care, it will not be possible to match the standard of service that the public have come to expect, and there will be a need for radical changes in the way that services are delivered. Some very tough decisions will have to be taken.

In the current year, the Health and Social Care Board has already put forward a commissioning plan indicating some of the changes in services that are needed anyway. However, if the Executive decide not to give substantial protection and priority to health and social care, the scenario would be much graver, and sustaining safe, high-quality services would become much more difficult. We will, therefore, need to look at which services can be sustained and those that might need to be scaled back. Can we offer a full range of services and therapies? Is there a need to take out the fixed cost in delivering health and social care facilities? Facilities would have to be closed to save substantial and fixed costs. That is just the way that economics work. All those things would come into question and might have to change.

If substantial protection is not given, the commitments and promises made over the past number of years would be called into question, because the financial situation would have changed so significantly. As you said, Chairperson, we are facing the most challenging period in our history. We are facing extremely important decisions. Obviously, there are many issues faced by all Departments. However, it is important to get into a discussion about the nature of the issues that we face as a Department. We can guess at some of the scenarios, but we are mainly waiting for clarification from the Executive about the approach that they will take to those issues.

The capital position is also very serious, as has been highlighted significantly in the media. I will briefly outline how our system works. The flows are less complex than those in the diagram provided that deal with the resource budget. Several important parts of the capital budget involve ongoing delegated capital budgets belonging to the trusts that keep things ticking over, maintain basic services and provide for ICT and so forth. Most of the focus tends to be on major capital projects; John Cole and the health estates team advise the Minister and work out the capital programme. The projects are managed by the relevant responsible organisation, whether it is the trusts or the primary care providers.

Management of the budget is co-ordinated by the health estates team in the Department. That

provides a simpler decision-making process and allows the Minister to oversee the prioritisation of projects and assess what most needs to be done. As everyone is aware, there is a high degree of need for capital investment in health and social care. Many projects that we had hoped to take on during the period of the investment strategy are well behind, which means that some difficult choices will have to be made as we go forward.

I hope that that is a sufficient introduction. Concerns about historical underfunding remain, as the Minister has pointed out on many occasions. If those are not identified and addressed, we will be looking at a potentially grave situation.

The Chairperson:

We will probably have one or two more discussions on this issue between now and February. I suspect that this is just the opening salvo. I want to ask one or two questions that are pertinent at the moment. First, you said that, as a result of the Barnett consequential, the overall cut was less than anticipated; but, there is nothing to force our Minister to freeze spending at the cash-limited figure of £4·3 billion. He can reduce that, increase it or do whatever he wants; there is nothing in the Chancellor's statement to compel him to retain current spending.

Given your experience, will you tell us exactly where we stand with the £18 billion capital infrastructure promise that was signed at St Andrews? About 10 days ago, the Secretary of State gave an assurance that it was protected; it was ring-fenced and was going to be delivered. Some of it was hypothecated for health. Where do we stand with that? The media reported this morning that that promise has not been replicated in the Chancellor's statement. Do you know anything about that?

Dr McCormick:

I am afraid that I do not know enough about that to comment on it with any authority. I have a concern that the figures published present a very challenging scenario for investment in health and social care. I cannot unpick the £18 billion or establish what is different between what was explained at St Andrews by Gordon Brown and the position now. I think that there are some differences, but I do not have details on those.

The Chairperson:

Does anyone know when we are going to get clarity on that issue?

Dr McCormick:

I am very confident that my colleagues in DFP are working intensely on that matter. I am sure that they are providing information to the Minister of Finance and Personnel, the First Minister and the deputy First Minister. I am sure that briefings have been done, but I do not know the details.

The Chairperson:

What about the capital elements?

Mr Easton:

What is our capital at the moment?

Ms Catherine Daly (Department of Health, Social Services and Public Safety):

The capital budget in the current year is just over £200 million — £201·7 million.

Mr Easton:

Is that for the current year? Can that go on top of —

The Chairperson:

That is for the current year. I do not think that there is any guarantee that that is what we will have for 2010-11.

Dr McCormick:

Exactly.

Ms Daly:

The starting position for a capital budget in any budget period is a zero baseline. That will be a matter for the Executive to decide by agreement with the Assembly.

The Chairperson:

But, £100 million of that is committed to existing contracts for PPPs, maintenance and other requirements. You cannot renege on those aspects.

Dr McCormick:

That is right. There are substantial commitments for next year and beyond. There is an ongoing need to invest around £100 million a year to keep the system ticking over. If major capital projects are delayed, it becomes necessary to spend capital in the short term to keep buildings safe and useable.

That is something that needs to be reviewed. If a trust is confident that there will be a new facility in five years, it can take one attitude. If it knows that it will have to keep the building in place for 10 more years, then it will be worth spending more money to improve it a little bit. Those are difficult decisions for the trusts, the health estate and the Minister; they have to make a balanced judgement on the best use of limited capital resources. We are very concerned about that.

Mr Easton:

I understand that the money spent on maintaining buildings will go up if new ones are not built.

If one takes the 38% cut in capital that we are apparently getting and subtract it from the £201 million, does that mean that we are talking about £124 million next year? Is it as simple as that?

Dr McCormick:

No; the 38% reduction is by the fourth year. The total budget available for Northern Ireland goes down quite steeply between 2010-11 and 2011-12.

Mr Easton:

So, it is not 38% straight away?

Dr McCormick:

It is 27·5% in real terms in the first year. It goes down progressively so that, by the fourth year, it is 40%. That represents £538 million of the Northern Ireland total of £1·000223 billion in 2010-11, of which our share is £210 million.

The Chairperson:

It worries me that you are committed to the £100 million from your capital budget to maintain what you have already, and you have commitments such as the Enniskillen hospital, which you

cannot get out of because it is a private finance initiative (PFI) and you have signed the contract, and you are expected to find 27% from what is left. Will there be any capital left for any major project if that happens?

Dr McCormick:

There will be very little left and there will be some very hard choices to make. There has been a change in the treatment of the Enniskillen project in accounting terms, so it is less of a problem than it was. The Treasury changed the way that the project was brought to account in public expenditure terms last year. So, half of the Enniskillen contract will not be hit by the budget. The situation is not quite as bad as you describe; it is close, but not quite as bad.

The Chairperson:

The knock-on effect for the construction industry in Northern Ireland will be extremely serious. The private construction industry is on its knees. I have never seen it as bad in south Down; contractors are going bust left, right and centre. They are depending on the public sector, particularly work in the health sector, to keep them going. You have so much money committed already that you have very little for new capital projects next year.

Dr McCormick:

That is true.

The Chairperson:

Does that mean that we can forget about projects such as the Omagh hospital and the new maternity hospital at the Royal?

Dr McCormick:

It will be possible to sustain some new projects, but some very tough decisions will have to be taken on what those will be.

The Chairperson:

When we went to the Downe Hospital, John Cole gave us very little hope about capital expenditure. He was basing his comments on what was already happening, not on the new information. It seems that there will almost be a complete winding down of newbuilds and major maintenance in the health estate next year, and it will get worse, because you are expected to find

38% over the four-year period. What will be left if you take 38% away given your prior commitments at the end of year four? Where will the spare cash be for capital investment in year four?

Dr McCormick:

That is a very difficult issue that Ministers and the Executive will have to address.

The Chairperson:

I presume that there will be no 3% efficiency savings on top of all that. I assume that we can forget about the need for efficiency savings and that there will just be a straight budget reduction.

Dr McCormick:

By no means will that be the case. Depending on the final decisions taken on the resource side by the Executive, in order to attempt to meet the demand that we expect due to demographic growth and additional opportunities to deliver health and social care to the standards that the public expect, there will still need to be significant improvements in efficiency and productivity and service changes on top of that. That is even in the best case scenario. That is what David Nicholson means when he says that the NHS across the water, with its much more favourable settlement, will find it a challenge to make £15 billion to £20 billion of quality and productivity savings. He said that last year, and he now says that that has been borne out. To convert that to Northern Ireland terms, I normally divide by 40 to get a scale factor. I think that the best-case outcome is approximately £500 million a year of further quality and productivity savings being needed in Northern Ireland to balance the books. The challenge is immense.

Even if the Executive decide to provide a settlement that is similar to what is provided for the NHS and social care in England, we would still face a challenge on productivity of that order to meet demand and provide the standard of service that the public expect from acute services, community health services, domiciliary care, and mental health and learning disability. All of those things are there; the public expect them. The service has been gearing up to look at how that can be made possible. That is part of the work that we have been doing over the past number of months.

The Chairperson:

We all sat glued to our radios yesterday — sad people that we are — listening to all of the

discussion. Afterwards, commentators talked about the English National Health Service. They said that about 5% of staff a year leave, retire or go off ill. They said that natural wastage, if planned properly, could bring about the savings that are required on the revenue side. They said that the capital position was as bad as what you are saying. They could not see how savings would be made. Have you any idea of the staff turnover in your Department? Would that be sufficient to achieve what you have to deliver without the need for compulsory redundancies?

Dr McCormick:

That is what the Minister hopes to do. The pattern has been of similar levels of turnover of staff in recent years. Martin will probably be able to help me. The pattern in the current year is that turnover is less than it has been. That is not surprising given the wider economic context: people are feeling less secure, and those who have a choice are more likely to choose to stay in their job. Turnover is down, which then makes it more challenging to deliver service changes and efficiencies without looking at workforce change.

The Minister's first determination remains to protect jobs in the Health Service because they are absolutely needed to deliver the care that people need — we are a people-dependent service. Anyone who has had any service from health and social care over the past number years knows that it is all about the quality and commitment of the staff throughout the service. That is what it is all about. Maintaining jobs, morale and motivation is more important than anything else that we do. That is what we aim and try to do. What lies ahead depends fundamentally on what the Executive decide. There could be scenarios in which the level of financial requirement that is placed on us exceeds the opportunity of the service to balance the books and live with the normal turnover of staff, as you described it. That is a major issue that will affect nursing and social care and all of the other professions.

Mr Martin Bradley (Department of Health, Social Services and Public Safety):

The average turnover in recent years has been running at around 6% or 7%. If we had a sensible realignment of our services, it would be possible, in normal times, to achieve that. If, however, there will be a fairly dramatic change in the service, it may be difficult to do that. As Andrew said, turnover is decreasing because, in a recession, people want to hold on to their jobs. They become more concerned about the money that is coming into the household. We are the biggest employer in Northern Ireland, with more than 70,000 staff, over 80% of whom are women. Many of them are the sole breadwinners. People are reassessing what they are going to do. Turnover is

continuing to drop, and most of the trusts are trying to keep within budget and have vacancy controls in place. Therefore, when staff leave, they are not being replaced as quickly as they had been previously. All of that is putting extra demand on the system.

As Andrew said, if the patterns of the past 10 years existed today, it would be achievable. However, if there is to be a substantial cutback in the money available to us, some decisions will have to be brought forward more quickly. On the back of significant closures and downturns in health and social care in Northern Ireland, nobody can guarantee that we could sustain that without employing fewer people and not being able to do so in as timely a fashion as we have been able to up until now.

Mr Gallagher:

You outlined your view on capital development. How will that impact on the radiotherapy unit that you propose to build at Altnagelvin Area Hospital, to which the Irish Government are contributing? I understand that the Western Health and Social Care Trust has a business case with the Department. Will you give me an update on that?

Where do we go from here with capital development? If we reflect on our discussions this afternoon, then the issue will get no further at Executive level. It will simply be rubber-stamped, and we will be told to get on with it. Will you be making a case, through the Minister at Executive level, for some capital development priorities? If that case is not made, we will simply remain in this position. As the Chairperson said, we hope that the Executive will take account of the construction industry, which involves many jobs and much money that would benefit everyone in the community.

Dr McCormick:

This is very difficult territory. The radiotherapy project is a high priority for the Minister, and for the South, because of the needs of the community. It is vital to provide that therapy for people who suffer from cancer. Our projection is that we will need additional capacity in a few years' time, which is why the project is among the highest of the Department's priorities. However, choices will have to be made. The business case is with DFP, so it is moving on, but the final decision on confirmation of the money will depend on there being enough to make it happen. Over the past number of years, the Minister has consistently and continually made the case for the revenue and capital budgets for health and social care; there is no holding back in any way.

However, that needs to turn into decisions and clarification.

Chairperson, when you mentioned a February deadline, that alarmed me a bit. We need clarity on some issues as soon as possible. The health budget is mainly driven by the cost of paying staff, so it is good to have clarity on the number of staff that can be afforded with, ideally, a six-month horizon. When I worked in DFP, there was a consistent pattern of needing to have final decisions on budget allocations before Christmas. That allowed the main spending budgets to plan sensibly to translate top-level Executive decisions into detailed spending plans in the period between Christmas and the start of the financial year in April.

Our Minister is very concerned about the need to ensure that decisions are made in good time so that we have an orderly planning process. He will, obviously, argue that health and social care should be given the highest possible priority, but whatever the outcome, good or bad, implementation will be vastly more difficult if issues are delayed, and, for every day beyond Christmas that they are delayed, it will become much more difficult. The longer that those decisions are delayed, the worse the actual implementation will be, and that will impact on the quality of how things are managed. That is really quite central to all of this.

Mr Gallagher:

How much capital is required for the Altnagelvin initiative?

Dr McCormick:

We can get the figure for you. The working assumption is that not all the capital costs will fall to our budget because the Government in the South will also make a contribution, which you mentioned.

Mrs O'Neill:

I have a brief question. We are slightly hindered in our discussions today because we do not know what the Executive will put on the table. When Colin was last here, he talked about how the Department was planning for the worst-case scenario. What has the Department done at this stage to work toward the budget? What has happened with PEDU? Where is that sitting at the minute? I would like a bit more detail on that.

Dr McCormick:

There are further ongoing discussions with DFP on the approach that PEDU will take. The Minister will be considering the possible terms of reference for that in the next week or so. Some work has already been done in the health and social care family to identify possible ways to manage with a reduced budget. The intention, therefore, is to look at the thinking that has already taken place rather than get a new team to look at the issue from the beginning. Some important work has been done to establish the options, and some advice has come in on that basis. It is further proposed that PEDU will assist with implementation. However, we cannot really start that work until we know the type of budget challenge that we are facing. Even in the best-case scenario, there will be an implementation and management exercise.

Part of the difficulty that arose from the efficiency savings in the 2007 comprehensive spending review was the need to manage a lot of projects and to secure implementation and delivery of savings. That is not a trivial thing to do. It is not just a matter of taking some broad brush decisions; rather, everything needs to be managed through a process to ensure that the impact is as good as possible. Therefore, given that there may be a requirement to make a certain level of savings, PEDU might be asked to look at how best that could be achieved.

Mrs O'Neill:

Are you saying that the terms of reference have not been signed off?

Dr McCormick:

Not yet, no.

Mrs O'Neill:

I think that Sean said at the last meeting in September that we were due to get or hoped to have the report by the end of October. That is obviously impossible. At this rate, will we get it this side of Christmas?

Dr McCormick:

Again, that will depend on DFP. It has a big responsibility in commissioning this work.

Mrs O'Neill:

I find it incredible that the terms of reference are still not agreed. It has been six or seven weeks

since Sean told us that the terms were possibly going to be agreed the following week, and yet they have still not been agreed. That is not very helpful to the Committee, given that we need to look at what inefficiencies exist in the Department. That group of work is a very important part of the jigsaw that will enable us to analyse the budget properly.

The Chairperson:

It looks like that will come too late to have any realistic input into your planning for next year.

Dr McCormick:

I hope that the work that the health and social care system has already done with some external help will allow the PEDU team, whoever that team is, to scrutinise and to take a quality-assurance view of what should be done. However, if the team identifies further areas that have not been explored, that process might take a bit longer. It is still possible to get an analysis of that process in a short time and there are further ways forward there to ensure that we move on. A very important dimension will be to see assistance with implementation.

Mr Easton:

You said that the revenue side reduction came to about 6·9%.

Dr McCormick:

Yes, that is the Northern Ireland total.

Mr Easton:

Will that be imposed in one go or will it be phased in over four years in the same way as the capital?

Dr McCormick:

Yes.

Mr Easton:

Front line services must be protected. Has the Department done any work on the impact on what might be construed as front line services to help the Committee with its thoughts on what to do to try and help you.

Dr McCormick:

That 6·9% is the Northern Ireland cumulative reduction by the fourth year, 2014-15. It is distributed relatively evenly, within a point or two a year, so it is a steady decline, in real terms, over the four-year period. The reduction is not as steep or sudden as that in capital spending, which faces a very sudden reduction in 2011-12. The change, in real terms, on the revenue side is more even.

Mr Easton:

Are you talking about around 2% a year?

Dr McCormick:

Of that sort of order, yes, that is right. Martin Bradley will answer your question on front line services.

Mr Martin Bradley:

Chairman, I am conscious that you also asked the question that Mr Easton has asked about what we mean by front line services?

The Chairperson:

I asked regarding capital expenditure. It is, obviously, vital to answer the same question on revenue.

Mr Martin Bradley:

Well, I am more on the revenue side of the debate.

Mr Easton:

OK, go for it.

Mr Martin Bradley:

I do not want to be misconstrued as not answering the question. The simple reality is that the vast majority of health and social care is front line. The provision of health and social care is one of the few services that any society depends on for the very basics of life, including life-saving interventions, treatments and therapies that create and sustain health and well-being. All of those are front line and were recognised as such in the spending review in which the Department of

Health in England secured an inflation settlement, compared to very substantial cuts in other Departments.

In considering where we are going with this and the demand that we will face over the next four or five-year period, a look at the demography in Northern Ireland shows that, over the next 10 years, the number of people here over the age of 75 is projected to increase by some 40%. Published in the last week or so, the Chief Medical Officer's report identified that one in 14 people in Northern Ireland aged 65 have some form of dementia, with that ratio rising to one in six in people over 80 and one in three over 85.

If we take that as the context, the front line extends from helping an elderly person at home who is frail and who needs help with personal hygiene, eating and nutrition, right up to open heart surgery. All of that is front line. We sometimes hear stories about people in the Health Service going around with clipboards and the number of administrators. We must remind ourselves that, as far as I can see, health is the only service in Northern Ireland to have embraced the whole RPA agenda. As we have told the Committee previously, the total number of senior executives in the service has been reduced by more than 40% and about 13% of middle managers now help to deliver services.

Some people say that medical secretaries, for example, are not front line. However, without the medical secretaries, how do we get appointment letters out? How do we make sure that case notes get to the right out-patient clinic, and so on? We have to keep all those issues in mind as we move forward with even greater efficiencies in particular services.

The other aspect of front line services is the public health agenda. Before I came into the room today, the Parliamentary Under-Secretary of State for Public Health, Anne Milton, announced an investment of another 4,500 health visitors in England to proceed with the public health agenda. That is another example of how we are getting further and further behind as far as public health is concerned.

I do not know if that helps you at all, Alex.

Mr Easton:

It does a wee bit. I believe that a lot of the revenue is for front line services, but not all of it.

Reducing sick days is not a front line priority, nor is the money that we spend on art, management consultant fees, negligence claims, legal aid, travel claims or North/South bodies — no offence to some members. There has to be some scope to look at some of those issues.

We are looking at reducing by 2% each year. That would be less than the 3% efficiency savings, except that you got the 3% back. In your own mind, Andrew, is it as bad as you feared, or do you think that you have some scope?

Dr McCormick:

I am still afraid, because I do not know what it is going to be yet. The Northern Ireland total is 6·9%. Our best hope is that the outcome for health and social care is, as is the case in England, a 1% growth in real terms. That is what we aspire to and what we need to prevent us from falling further behind, given that our starting point was that we are the poorest-funded health service in the UK.

The recently-published Treasury figures showed that spending per person on health in Northern Ireland is only 98% of the UK average; we are 2% below the UK average, despite having a 14% to 17% greater need for health and social care. I am still afraid, because until the Executive make decisions that protect health, we could face a 2% reduction in real terms. If the Executive simply say that each Department should take the Northern Ireland average, we would be down by 6·9% in real terms. That would mean that we would not be able to meet the demands and expectations of the public, nor would it be possible to sustain the NHS model in Northern Ireland. That is an enormous decision, and it is something that we need to face up to. There is a major challenge here; the figures are so uncertain at present, and we need to resolve that issue and move forward as soon as possible.

In the matter of front line services, I want to assure you that all the organisations are bearing down as much as they reasonably can on all the costs that you mentioned. Travel is sometimes necessary to do the job; there are front line staff who have to claim for travel to their jobs. Travel connected to management and leadership is under tighter scrutiny and control than it has ever been. Our objective is to minimise the costs associated with negligence claims and so on, but that requires us to ensure that we have the right quality of leadership and staff in all the professions. In turn, that requires investment in continuous professional training and development. All those things matter to ensure that safe and high quality services are delivered. The management task

requires able and committed senior managers. Those who are man-managing the organisations have jobs with a wide span, with many demands. I work with those people day and daily; they seek to do the very best that they can to deliver efficient, high quality health and social care.

Mr Martin Bradley:

I would like to return to Alex Easton's point about travel. In my profession, district nurses made 1·5 million visits last year to people in their own homes, and health visitors made 500,000 visits to people in their own homes. When you think about that quantum of activity and the fact that they have to move around the community, you can see how travel costs are an issue.

Mr Easton:

Yes; there is no doubt that they are high, but it is not all for that. I do accept what you are saying: a large chunk of it is.

Ms Daly:

As regards the 3% efficiencies in the last Budget process, it is not exactly the same this time. The 3% was set against increasing baselines, so, even after the 3% reduction, Departments still had significant uplifts in their baselines. At the block level, it is quite flat this time — a small increase. Therefore, the savings are much greater and more significant than in Budget 2007.

Dr Deeny:

You are welcome, ladies and gentlemen. Doom and gloom, is it not? I have not seen a smile for the past couple of days.

I want to ask about community care. There are some worrying things about this, and I am sure that the public are worried. The whole foundation of the NHS is under scrutiny — it is the first time that I have come across this. It is a worrying time. We all know that a lot of care provided by the NHS is provided in the community. We all tend to over-focus on buildings and hospitals. For example, we know about, and we welcomed in the community, care moving from the secondary sector into primary care. We were up for that. Now, because of capital and infrastructure, it looks like we are going to have no new health centres in the future. That is a concern.

If the budget for the Health Service in Northern Ireland is ring-fenced, or not, what will be the

difference for community care? For example, I was in my health centre for an hour or so this morning. We are talking about doing more minor surgery, if we can, to help out our hospital colleagues, but we do not have the room. That sort of thing is going on, which is another worry. Does devolution mean that we are going to end up falling behind other countries as far as our health service is concerned? It is a worrying development. It worries me, as a doctor. We have insufficient junior doctors coming through at the moment, and if those who do come through feel that there is a better deal and a better working environment in England or Scotland, they will go there. I trained in Dublin, but I came back. Many of us come back because we love the place, and we work here. I am talking about nurses too. Martin also referred to midwives and ex-nurses. They want to provide the same level of patient care as in England, Scotland and Wales.

That is how important this is. If health is not ring-fenced, we are liable to fall behind, both in the standards of care that we provide and in our ability to hold on to our top health professionals, be they midwives, nurses or doctors. That is a concern. What do you see as the impact — as an intelligent estimate, Andrew — on community care overall if this is, or is not, ring-fenced? Are we going to be working in dilapidated premises and outdated health centres?

Dr McCormick:

It is already an issue. It is not a matter of the risk of falling behind; we are already behind, and the risk is of falling much further behind. I have already given the financial comparisons. This is not just a matter of numbers that we can make up for. The fact is that we are already not providing the same standard of care in Northern Ireland as is possible elsewhere in the UK. Elective surgery is a good indicator. For several years, England has had a commitment to delivering an 18-week timetable from GP referral to the completion of day case treatment. Gordon Brown wanted to put that into the NHS constitution and make it something for which a patient could go private if the health service could not deliver it. That is the extent to which they were committed to that as a target.

The best that we got to was to first outpatient appointment in 9 weeks; diagnostics in 9 weeks; and then inpatient or day case treatment in 13 weeks. That was the best that we got to. We were close to achieving that in 2008-09. Since then, directly because of our funding difficulties even now, we have slipped back. We now have, as of June, 29,000 people waiting more than 9 weeks and 15,000 waiting more than 13 weeks. That is for outpatients; for inpatients it is nearly 10,000 waiting more than 13 weeks. We are already behind, and if there is not protection and priority for

health and social care in Northern Ireland in this Budget, we will fall significantly further behind on that kind of indicator.

Community care will be one of the areas that will be difficult to fund. As well as the issue of investment in facilities and premises, it will be much more difficult to facilitate the transfer of more service from the acute sector to the community sector. Nobody wants to be in hospital. There is so much more, as you will know better than any of us, that can be done in a primary care setting. That is the way that we should be going. It is also fundamental to the reforms on mental health and disability, where the extent to which we are still dependent on institutional care rather than care in the community is an indictment of our society.

The Bamford report happened, as an initiative, because Northern Ireland was behind. In the worst case funding scenarios that we are looking at, we will fall very substantially further behind. In the best case, we will still be behind, but not getting so much worse. There is no optimistic scenario available. I am still not smiling, I am afraid.

Dr Deeny:

It worries me, because the National Health Service as we have known it since 1948 has always been uniform and standard across the country.

Dr McCormick:

That is what people expect.

Dr Deeny:

If we get disparities and differences in treatments and outcomes, with health professionals preferring one to another, the health service will be gone. That is a big concern. We have to get our act together and look very seriously at this. The people whom I work with certainly expect to work with the same type of nurses, health visitors and social workers as they would in Scotland. If that is not going to be the case, it is a very serious situation.

Dr McCormick:

I think that that situation applies quite starkly on the social care side and in children's services.

Ms Christine Smyth:

I agree with what you have said about community care and looking at the system as a whole, because we are a health and social care system, and the interdependency between healthcare and community care is very real. If we do not protect both health and social care and recognise that interdependency, we are going to put inordinate pressure on the acute sector in health. There will be delayed discharges and inappropriate hospital admissions. We have 185,000 carers supporting people in their own homes, which takes a lot of pressure off the health and social care system. If we do not continue to support them and that breaks down, it is going to put even more pressure on our system.

As regards employment, and how we deliver community care, it is not just our statutory health and social care sector that is an employer. The voluntary sector is an employer as well, and we also have the private sector, which delivers a lot of social care, domiciliary care and residential care. We will be affecting employment across several sectors.

Mr Gallagher:

It is already happening: patients are being held up in hospital beds because the money is not in the community care budget. That is very hard to understand, given that it takes £2,000 a week to keep somebody in hospital. They could be in a nursing home setting, or back in their own home, for well under £1,000 a week. There is something wrong with that?

Ms Smyth:

Obviously, decisions regarding budgets and allocations with health and social care are difficult decisions to make in both the acute sector and the community care sector. When you have somebody presenting with an emergency at a hospital, that needs to be dealt with. Getting the balance right is very difficult, but we go back to the issue of underfunding. When Appleby reviewed services in Northern Ireland, personal social services were about 35% underfunded compared to social services in the rest of the UK, so we are starting from a much worse baseline than anywhere else in the UK. There has not been a shift. It is a bit of a vicious circle: if we cannot get people out of long-term institutions and move the money with them into community care, it gets stuck in the institution that is caring for the people. That is a real challenge for us.

Mr Girvan:

I come back to Martin's point about managers, senior managers and the supposed reduction in

numbers. I know that statistics will show whatever one wants them to show if questions are asked in the right way. I had occasion to speak to a nurse no more than two weeks ago. She told me that, 10 years ago, she was answerable to one person; today, she is answerable to five. She is doing exactly the same job in a trust. There is no need to look amazed; that is endemic throughout the organisation. Anyone who has any knowledge of the service will say that that is what is going on. I cannot see how there has been a reduction in the number of managers and senior managers in the service and how savings are being made?

I appreciate that the figures have been presented in a very bland way, but it is hard to drill in to the detail. I know that we are looking at where savings can be made effectively, but there has to be fat somewhere in a turnover of £4·3 billion. I have had occasion to use the Health Service in recent days. My family have done so for a number of years. Operations have been cancelled a number of times because of beds being occupied by people who, as Tommy alluded to, could be transferred to a nursing home at a cost of £530 a week instead of sitting in a hospital bed at a cost of £2,000. You tell us that that does not happen and that there is no such thing as bed blocking. It is all about people protecting their budgets in their wee ring-fenced areas. I am looking at the overall picture, but that is not what others are doing. Everyone wants to sit in their wee ivory tower and look after their own wee department. They have the attitude of "As long as we are happy, Jack, on you go." That is what is happening. I would like details of exactly how many senior managers there are. Some of their job titles have changed, but that does not necessarily mean that they are no longer management. I would like breakdowns of those figures because the issue is the money that goes with those posts. I am very wound up about it because I see a lot of waste. I have suffered from that, and I know families that have. It really gets to me.

The Chairperson:

The Committee has asked Research Services to come up with information on all staff who earn over £40,000 a year. The issue was raised several times before you joined the Committee. We are doing research in that regard. There is still the perception — I have had it in meetings with the various trusts — that there may be fewer chiefs, but some staff answer to more chiefs. That seems to be inefficient.

Mr Girvan:

We do not get to find out what is classed as front line, but nurses and other staff who deal with patients daily are the ones who seem to have more managers above them.

Mr Martin Bradley:

I do not disagree with Mr Girvan about some of those issues.

Mr Girvan:

I can give you names and details if you want them.

Mr Martin Bradley:

It is a huge service. It is by no means perfect in every respect. We have already acknowledged that, in a budget of that size, there will always be efficiencies to be made. Indeed, we have always been bearing down on those efficiencies. I know that Andrew will probably want to say something about RPA because it speaks for itself about what that part of public expenditure in Northern Ireland has been able to achieve over the past couple of years.

To be more specific, I know of the scenario that Mr Girvan has painted, and the nursing directorate in the Deaprtment has done a lot of work over the past 18 months with our ward sisters to try to make sure that, as far as possible, they have control of their own ward and make as many decisions as possible at ward level for their patients. To be fair to our Minister, he has supported that to the hilt and has said that, at the end of the day, the ward sister is in charge, even to the point that if he goes onto the ward, the ward sister will tell him if he needs to do something.

There has been a culture in the system, not only here but across the United Kingdom, where that power base has been whittled away for a variety of reasons. That is probably because of the general management culture, where people have been very concerned about the amount of money in the system and do not want people to make decisions further down the line because of the fear of the consequences. To a certain extent, that is a side effect or an unintended consequence of having less and less money. I know that, in some places, a requisition must be done four or five times before it is filled out, or it goes through four or five hands before it is filled out. Organisations get into that sort of behaviour when they become more and more concerned about the amount of money that has to be spent. At the present time, we almost have to go to a Star Chamber to get relatively small works done. That is a symptom of something else that is going on in the system at the moment.

Mr Girvan:

That does not necessarily relate to health only. It is endemic throughout the public sector. We are looking at the overall issues of the public sector.

Dr McCormick:

George Osborne challenged the NHS across the water yesterday and said that, despite the settlement, it still needs to improve productivity. That applies where we know that there is a need to address that issue.

One significant aspect of the change under RPA was the creation of five integrated trusts. Before that, some trusts had acute services, some had community services and some had both. There was a mixture across Northern Ireland. The move towards consistency means that — I am trying to address the point about defending small patches — there is a responsibility on the organisations to manage across the full range of services. For example, the only way that the manager responsible for the A&E department can hope to meet the targets on A&E is by addressing the very point about discharges.

The buzz phrase is "whole system reform", and we are trying to drive that through and to make the organisations look across. They want to do that anyway, because the management teams are motivated to that goal. We certainly need to make sure that there is no impediment to that in the structure or no overly bureaucratic requirements for approval. We need to facilitate front line decision-making that is efficient and effective and maximises the benefits of integration. We do not have enough actual integration, even in health and social care, and there is a need to do better on that. I recognise all that.

That does not take away from the general funding position that we are facing. To succeed in those terms and to deliver in the worst-case budget scenario, everybody will be required to behave at Olympic gold-medal standard. Realistically, human behaviour is normally distributed. Some people will be excellent and some will not be so good. That is the way humanity is, and we need to respect and recognise that while still driving for excellence and improvement. The trusts that have been in operation since 2007 have considered issues on an integrated basis. That is what it is all about. Again, we need to continue to look for good practice in organisational management. That is part of what is needed.

Mrs Mary Bradley:

In my trust area, I have had great difficulties with community care. I know one gentleman who spent sixteen-and-a-half weeks in a hospital bed. The doctors urged the hospital to get him out into the community. Although his wife, who was at home, wanted him at home, he wanted home and the doctor wanted him out, the trust could not provide him with the carers to enable him to come home. Therefore, he spent that time in the hospital bed, and he took up a bed for that time. The man did not want that, and neither did his wife. They wanted to work as well as they could with the health trust, but it could not provide for that.

A further example is that of a 90-year-old man, who lived with his wife in Claudy. His wife died suddenly. He had been the healthier of the two people, and he had not needed any help when she was alive. I could not get care for him for one hour a day. I was told that I would have to wait until someone else died to get him an hour of care. Where are we going with that? People are at their wits' end over the situation. People need support to be able to do the job.

Provision of speech therapists is extremely short in our area. Jobs get advertised, but, for whatever reason, we cannot get people to apply. I can identify a school that has one first-year class with 13 children waiting for speech therapy. What does that tell us, and where are we going with that? That is the years in which we are supposed to be educating children, and speech is very important to their education. All of that needs to be addressed. Where does that come into front line services?

Dr McCormick:

Those are vital aspects of front line service that need to be given priority. That is clear.

Mr Gardiner:

Andrew, I listened to you and your officials, and I am very impressed. We are the elected representatives, and, in many ways, you are answerable to us. We want you to do a first-class job. You have explained some of the details to us and the gaps in the service that you cannot meet because of the financial restrictions that are being placed on you. As a Committee, we, perhaps, carry more of that responsibility than your good selves, because it is up to the Committee to push to get the services and finances available for you. We want a Rolls Royce Health Service in Northern Ireland, and we are striving for that. You have come a long way, much better than some other parts of the United Kingdom. I will be here supporting you, and,

hopefully at our next meeting, when the finance that is coming our way has become clearer to us, the Committee will agree to support the ring-fencing of health in Northern Ireland.

Dr McCormick:

Thank you.

The Chairperson:

There are a couple of procedural issues. Regardless of where we stand on the issue, we want to work in unison with the Department. Previously, the Committee was left in the dark on the budgetary adjustment when every other Committee had their facts and figures. We are quite insistent that that cannot happen again. We have asked you for your savings and spending plan, which Departments such as DCAL and DOE have produced already and presented it to their Committees. We have not received that, which augurs badly for the process that is ahead of us. Where are we with that? It is a document that you have prepared and offered to the Department of Finance and Personnel. Where is it? We need to see it pretty quickly.

Dr McCormick:

We will see what we can do about that.

The Chairperson:

The DALO is here, and I am sure that he will pursue that. Will you assure us that we will not be left in the position in which the other nine Committees, or 10 depending on how you look at it, have the relevant budget plans while we do not? We were left until two months into the financial year to be told what the 2010-11 outcomes were. We are not always on opposing sides, and there may be a strong argument for elements of ring-fencing or protection. Looking at what we have been told, any reasonable person may support that, but we can do that only if we have the flow of information that you can provide for us.

We must put a marker down by saying that we will work together and see whether we can find areas of agreement, because members have expressed concern about what is coming our way, particularly on the capital side. Is there a hope that we can work in tandem with the rest of the Committees?

Dr McCormick:

It is hard to predict exactly how the process will unfold. As far as the specific proposals on what the allocations will be are concerned, the ball is in DFP's court. We will do the best that we can to help the Committee.

The Chairperson:

I want us to be treated the same as every other Committee. We do not enjoy beating our breasts and saying that we are being singled out for unfair treatment, but we were, in the February readjustment. It was ridiculous that we got it at the end of May.

Do you wish to make one final point, Alex? Are you happy enough?

Mr Easton:

No. It depends; I was going to back what Paul said, and I was going to give an example. However, I am sure that you do not want to hear about it.

Mr Girvan:

Go ahead.

Mr Easton:

I used to work in the Ulster Hospital. I am not going to give you the specific example, but it was at a time when directors and managers had to apply for their jobs and we were reducing those. I know for a fact that, in the department where I worked, the unsuccessful candidates out of the four directors who went for the one director's job were all given new titles after the post had been filled. They were given lesser jobs, but their pay was protected and an extra layer of management was created. That is an example of the abuse that I saw. The jobs for the boys were protected in that instance, whether people want to admit it or not.

I want to help you and support you as much as I can, as does everyone in the room. However, I want to see a wee bit more information about what you consider to be front line services. If you want me to help you, and I genuinely want to help you, you have to give me a list of what you consider to be front line services. It is not good enough to say that the entire revenue budget is spent on front line services; it is not.

The Chairperson:

No one can define consultants' bonuses, the equality industry, public relations and HR as front line services. You are right; the vast bulk of revenue is spent on front line services, and I accept that. However, there have to be services that can be detached from that. There may be an argument that what is left over from the front line should be at least treated as it is in GB.

Dr McCormick:

It is important to say that the front line cannot function without an effective HR management function. That is part of what we are doing. The key element of RPA that is still in train is to help ensure that the support services for HR are provided on a shared service basis. That should be more efficient and should mean that more change is coming.

I will pick up on Alex's point about the directors. During the RPA process, the commitment given by the direct rule Minister and by Michael McGimpsey was that there would be no compulsory redundancies. As part of the terms and conditions of service, there are obligations to provide pay protection. That is not a secret; it is not something that we are ashamed of. It is part of what we are obliged to do in managing that change. We secured genuine reductions in the number of senior executives: that happened. As you said, some people who had been directors were re-employed in other jobs, but that was done on a contractual basis and because there were commitments to avoid compulsory redundancies. The measure of it is that the number of senior executive jobs is going down and the savings are being delivered. The vast majority of the £53 million that we were committed to delivering by April 2011 through the RPA has been secured as actual, demonstrable savings. We have nothing to hide on the RPA process; we are satisfied that it was done properly and defensibly.

Consultants do not get bonuses; they get merit awards based on an —

The Chairperson:

Andrew, five of them got £75,000 each for five years. If that is not a bonus, give me one and I will take it. Call it what you like.

Dr McCormick:

It is part of the UK-wide system of securing — *[Interruption.]* It goes back to the point that Dr Deeny made; does the Committee want to have good doctors working in Northern Ireland? I was

very glad last year to have a very good doctor looking after me.

The Chairperson:

I accept that, but in the present economic conditions we cannot allow that sort of largesse to continue.

Dr McCormick:

It is being reviewed —

The Chairperson:

It needs to be reviewed.

Mrs O'Neill:

Only a certain element is being reviewed. There is a local agreement; is that being reviewed?

Dr McCormick:

The consultant merit award system is being reviewed.

Mrs O'Neill:

That is the wider model, but they are broken down into two categories and there is a special local arrangement.

Dr McCormick:

Yes. The local arrangements in Northern Ireland are less generous than those in the rest of the UK. The whole approach is being reviewed.

The Chairperson:

We will be back; it will not go away, you know. I hope that that has clarified some issues. I am sure that we will hear about other issues can be clarified. Thank you.