Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

McKinsey Report

3 March 2011

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mr Mickey Brady
Mr Alex Easton
Mr Tommy Gallagher
Mr Sam Gardiner
Mr Paul Girvan
Mr John McCallister

Witnesses:

Mr John Compton	)	Health and Social Care Board
Mr Paul Cummings	)	
Dr Andrew McCormick	)	Department of Health, Social Services and Public Safety

The Chairperson (Mr Wells):

I welcome the witnesses to their weekly appearance before the Committee. I do not think that any of them need to be introduced to anyone around the Table, but, for the record, I welcome Dr Andrew McCormick, the permanent secretary in the Department of Health, Social Services and Public Safety (DHSSPS). John, are you a doctor?

Mr John Compton (Health and Social Care Board):

No.

The Chairperson:

You must be one of the few who are not.

Mr Compton:

I was a social worker a long time ago, but many people would say that I am no longer anything like that.

The Chairperson:

As all Committee members know, Mr John Compton is the chairperson of the Health and Social Care Board.

Mr Compton:

I am the chief executive.

The Chairperson:

Yes, of course. I am sorry John; I demoted you.

Mr Gardiner:

Who needs the medicine? *[Laughter.]*

The Chairperson:

I think that I do. Senile dementia is setting in. My only excuse is that I have had a rather fraught morning.

Also appearing today is Mr Paul Cummings, the director of finance in the Health and Social Care Board. Gentlemen, you could write the book on appearing before the Committee. I will give you the usual 10 minutes to make a presentation, and I will then open the session up for questions from the Committee.

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

Thank you, Chairperson. I apologise on behalf of Catherine Daly. She was here a moment ago,

but we just received the paper for today's Executive meeting, so she had to brief the Minister on the emerging proposals for the final Budget. The day is young.

I will begin by saying a few words about the background and context of the work that McKinsey and Company did for the Department last year. The contract was procured through what was called the provider development programme, the idea for which originated in 2008. During 2009, a procurement exercise was carried out, and McKinsey and Company was the successful tenderer. The objective of the exercise was to provide support to the provider organisations, which were mainly the trusts. Particular aspects of the terms of reference of that work involved the need to assist with change and to secure greater efficiencies. Those were very important aspects of the programme, and when we mobilised it last summer, we made the judgement that the work should focus specifically on them.

The team worked mainly through John, Paul and their colleagues on the board. The task also involved a lot of detailed work with trusts, local commissioning groups (LCGs) and other players to draw together a good understanding and analysis of how, looking ahead in a new financial context, health and social care can and should adjust. Given the new funding context, which we assume will create a much more restrained financial situation than we have been used to, and given the need to think about a realistic way of manageable change in that context, the point was also to consider the kinds of reform and transformation, which is a word that the team used, that will be needed.

That was the need for the programme. I think that the Committee has seen the published document, which gives a very extensive analysis, both as a summary report and a body of documentation. It uses high-level comparative techniques to assess the nature of the way that our services are organised, and it benchmarks them against practice elsewhere in the UK and internationally. The aim is to look at what is good practice and at how things can be changed and improved so that high-quality services that have to stay at the heart of the service can be delivered. There was a strong clinical input to the work. We recognise that the service change has to be considered and led on the basis of the best available professional advice. That is integral to the management and leadership of health and social care.

Clinical engagement and professional leadership is at the heart of this piece of work, which was done on a fairly broad canvas. It looks at the context of the funding pressures, projecting the

demands arising to 2014-15, and it considers the realistic potential to make savings. It looks at the strategies that could be adopted. When the work was commissioned, there was no predisposition and no ruling out or in of particular options. It was a matter of drawing on practice elsewhere and looking at change elsewhere. All that was done on a relative evidence base that was based on assessment of empirical evidence across the UK and more widely on what a high-performing health and social care system can do.

One point that we emphasise is that the team looked at benchmarks and set many of the standards, based on getting to a high standard of performance. That is a very important challenge for all of us. Most of the data that are presented describe what can be achieved if the Northern Ireland system were achieving at the upper quartile of performance across the wider UK context. That is something that we all aspire to. The fact remains that no individual system anywhere in the UK achieves consistently at the upper quartile performance range. If performance is distributed normally, we are looking at where the 75% mark would be in the distribution of performance on a range of issues. That is the nature of the challenge that was addressed. The team looked at a range of issues.

The status of this work is that the report and the accompanying detailed slides are consultancy advice. The Minister has written to you about that, Chairman, and he also wrote to his Executive colleagues making much the same point. He made it clear that, of the many ideas that are proposed and considered in this report, although some of them are acceptable to him, he will not be authorising specific action on them. He made that clear both in his letter and at the meeting with this Committee in January. That means that the report provides advice and that it is for further consideration and analysis. Lots of issues need to be considered, and lots of judgements need to be formed, many of which will be matters for consideration in the next mandate.

Before I ask John to give us further detail on the material, the final point that I will make is to say that the report is entirely consistent with the financial presentations that we have been making to this Committee since last September. We have projected the cost of running the system as we know it, absorbing all the cost pressures and meeting the projected levels of demand. If that were to continue broadly as it is, the cost requirement would be £5·4 billion by 2014-15. That is supported by benchmarked evidence on the trends. The work then assessed what could be done through change. The figure, which is familiar, given that we have used it in previous presentations, is supported by that work. If the Budget by 2014-15 were to be £4·8 billion, it

would be possible, subject to agreement to a radical change programme, to secure high-quality, viable services that would meet the main needs of the population. That is an enormous financial challenge and an enormous reform and transformation challenge. Even that includes specific elements that will be problematic, given the need for political judgements.

That has been our understanding of the nature of the organisational and financial challenge, and we can set that against our aspiration to secure high-quality services that meet needs with reasonable access and with reasonable degrees of local provision and so on. The McKinsey report gives a major analysis of that opportunity, but it is purely consultancy advice. Nothing has been agreed or endorsed; indeed, there are some serious issues with all of it. However, it makes an important contribution to the debate, which is why we are grateful for this discussion.

Mr Compton:

I am delighted to have the opportunity to make a presentation of the work that has been done. We forwarded a short report to each member, and I will talk it through page-by-page. I will try to do that reasonably consistently and concisely, and there will then be an opportunity for debate and discussion.

Reasonably enough, the report starts by asking what we are trying to do. We are trying to get better outcomes for our patients and clients. We also want to make sure that patients and clients have a good experience when they touch our system, and we rightly want to ensure the support of professionals for the change process while paying attention to value for money and the taxpayers' position.

We have worked closely with the McKinsey organisation in the development of this information, which provided, as Andrew indicated, supportive information for the Minister during the ongoing discussions in the autumn. A benefit of using the organisation was that we avoided the accusation of producing partial results and of reflecting a particular constituency position. In that way, we got objective measures, as well as, critically, comparative and benchmarked information. I will talk about that comparative and benchmarked information.

Our report tells us that this work is a design for a step change in our provision of health and social care. It indicates what we want to do to get a qualitative and value-for-money service. It explains how we will have to do different things in the community and how we will have to think

better and more cleverly about how we organise our hospitals. It indicates that, generically, that means fewer hospital beds, a much more important role for local hospitals and an entirely different role for primary care, underpinned with proper ambulance and transportation arrangements. It talks about the broad implementation issues of estate strategy, which includes sites and so forth. For me, it tells us that what we have now was and is a good service for the time for which it was designed, but that it cannot sustain itself into the future. The health warning on that is that it takes us to the performance point where we want to be, which is in the top 25%. Therefore, the enormity of the challenge in delivering that should not be minimised.

Our report shows that money and better health status are not inextricably linked. Spending more money does not automatically mean a better health status. The way that the resource is used tells us everything, and that is the important issue and a key theme throughout the presentation. For example, Canada spends more than the UK, but it is lower in the world rankings. However, Italy spends less than the UK, yet it is higher in the world rankings. It is about the organisation, model and delivery of care. There is an important balance to be struck between health status and resource.

We did the work by using outside analysis, which the organisation brought to us and which was quite detailed and critical. We benchmarked right across the UK and looked at good practice opportunities. We also did a lot of work with the board, the trusts and the Public Health Agency (PHA) where individuals had opportunities for debate and discussion. We sized the potential from a top-down point of view, and we particularly reflected the situation with the work that Appleby did on need in Northern Ireland. Members will be aware of the Appleby work and of the figures of 7% and 16%, which have been part of the debate. Therefore, the Committee can see that the report's presentation is comprehensive, independent and thorough.

The first point, and perhaps it is the most revealing, is that Northern Ireland is spending less than other UK regions in the current spending round. We did not necessarily expect to find that. We were talking about the base years, which are always a little behind. That is an objective piece of information. Although we can all operate by asking whether we are spending the money correctly or whether we have enough money, the objective evidence is clear and is in the information. It shows where we are in comparison with others.

If we look forward to how the current position can be built on, there are three key themes to

consider: demographic growth; residual growth; and unit price inflation. It is important to note that demographic growth is about not just an older population but total types of services and demography as the whole population changes. At the time that the work was being done, the information on that in Scotland was not available. However, we have had confirmation that the figures that we are using for unit price inflation are similar to those that are being used in Scotland. Therefore, the Scottish figure will sit at just a little over 5%.

That tells us that how we looked at the finance and the way that we projected it forward is accurate. It is not out of kilter with anywhere else in the UK, and its methodology is robust and difficult to erode or challenge. That is quite important, because it takes us to the nub of the whole issue, which is to ask about where we can go if nothing is done. That is how the £5·4 billion is reached. We have residual growth, and we took out all inflation and demographic money for a seven-year period backwards and found that our services were growing at 2% per annum. When we benchmarked that across the rest of the UK, it was found to be broadly in line with figures there. Therefore, that is how those numbers are arrived at. They are not manufactured or created numbers; they are based on very accurate information and fact.

The issue about the £5·4 billion is quite important. Whatever way this is looked at, that number is pretty robust. One can always find another way of calculating and looking at it, and the figure might be plus or minus £100,000, but, essentially, it tells us that that is where we are. In my view, it is not easily challenged, and it is critical to understand, because it tells us straightforwardly that we need a changed process, otherwise we will simply not be able to deliver the current model of health and social care. That is not the only driver for the change, but it reaffirms it.

Of course, it is not just about asking what we should have more of. Asking where we can get it from within the system is a perfectly valid and reasonable argument. The submission indicates right across the whole area where the opportunities are, and, in a sentence, it suggests how to sort out the delivery of hospital care. That is because the way that we organise our hospital care is simply not efficient. Sometimes there is a lot of debate about whether there is waste in the system and whether we spend money inappropriately and all sorts of other issues. The single biggest thing that we need to do to sort our expenditure out is to modernise our hospital sector. Anyone who goes into the community sector will see that, comparatively, we spend less than other parts of the UK. That is therefore a compelling and powerful argument, particularly for

areas such as mental health and learning disabilities.

Mr Gardiner:

Would you elaborate a wee bit more on where you would modernise and on the targets you would want to improve?

Mr Compton:

I will come to that in the presentation.

Mr Gardiner:

OK, I will accept that.

Mr Compton:

If we are talking about hospital care and the need to organise it, the model shows that the pattern of hospitals means that there are all sorts of variations that creep and grow in how that care is delivered and used. We get those deviations because we are not organised correctly between primary care, social care and hospital care. Therefore, we get more admissions in one part of Northern Ireland than another, because the system has to use what is there. It may not be the correct model, but it has to use what is there. That means that there is no uniformity. It might be expected, for example, that standardised admission rates for emergencies are the same across Northern Ireland. There is no reason, clinically or epidemiologically, to suggest that they would be different, yet the example in the paper shows that it is quite marked, ranging from 95 in one area to 111 in another. That reflects where the system is and where we have chosen to invest the money. People have to use what is there.

Need is another important issue. The model in the paper shows a clear deviation in life expectancy between those who, broadly speaking, are well off and those who are not and live in more difficult areas. The facts speak for themselves: if people live in a poorer, more deprived area, their life expectancy is less. That is just a simple fact.

The overall need weightings of 7% and 16% are interesting. The 7% is the agreed figure that the Department of Finance and Personnel (DFP) and those in the system use, and the 16% is what others may say is the actual figure. Irrespective of the figure that is used, it tells us that there is a significant need. Therefore, when the issue is built up back to the £5·4 billion and to the residual

growth and the demographics, it is supported by the needs arguments. Those issues are quite well joined, and they get to that position.

We could spend a lot of time saying that, qualitatively, we want to make the change; that financially, we need to make the change; that professionally, people want it to be made; and that those using the service of course want the system to be responsive and to have good outcomes and a good patient experience.

Knowing all that, what would we do to make the changes? The model tells us where to begin. It gives us a notion of how quality would be affected and of the financial impact and the ease of implementation. Therefore, it is clear that, qualitatively, long-term condition management (LTC), which looks at conditions such as asthma, diabetes and chronic obstructive airways disease, has a very high impact on people and a moderate financial impact and is moderately easy to organise.

Some issues are quite easy to organise where quality is concerned, but the ease of implementation is not so easy. Again, issues such as productivity point towards a review of the hospital sector in particular. Those are neither straightforward nor easy to implement or organise. However, that gives us a model of how to begin to address the problem. If we talk about wanting to make a step change, we have to be able to articulate what that may look like, the areas it would take place, and how it would be addressed and attacked. The model tells us what to do.

To give you a flavour of what that might mean, we spoke about long-term condition management and good disease management. If we take congestive heart failure as an example, the model tells us not to admit as many people to hospital but to make sure that they get better community support. It suggests, for example, that admissions could be reduced but that it is important to make sure that patients have two-and-a-half times more contact in the community and that they can maintain that in the community. That means that the outcome is better qualitatively and the treatment is professionally driven and advised. The same is true with asthma, chronic obstructive pulmonary disease and diabetes. Therefore, it is quite clear how the shift in that model delivers both quality and value for money, but it requires transition and change.

If we make that step change, we need to understand the £4·8 billion figure, instead of running away from the £5·4 billion figure. The £4·8 billion figure suggests that there can be cash savings,

which can be made through efficiencies, as will productivity. There is a need to discriminate between the two; productivity means that we can do more activity but not necessarily deliver cash. The submission shows that the way to handle the transition is to do both.

A certain amount of cash comes out of the system to allow us to reinvest, but, as a consequence, we make the system more efficient, which means that we are able to absorb things such as residual growth or demographic pressures without resorting to the model that leads back to the cash position of £5·4 billion. That is quite a coherent way of looking at the situation, but, again, it requires a commitment to the change process.

What will the model look like at the end? We did not go into that in the presentation, because we did not think that it was appropriate to get a list of every facility in Northern Ireland and describe what each would do. However, it is clear that we will have a new way of delivering integrated care. We think that there may be somewhere in the order of 17 such facilities. There could be a different role for local hospitals, and we think there would be fewer larger and major acute hospitals running the 24/7, 365-days-a-year model.

That would be underpinned in integrated care by a different way of handling the social care arrangements and by looking at social care in an entirely different way. If we were to go back to the interventions about where we would get the productivity, the efficiency and the cash, we would find that social care is one of the major streams. Therefore, there is clarity about what we would do and how we would approach the change.

The model of the out-of-hospital system shows that, at the moment, there is a range of GP practices, health centres and community hospitals dotted around any given area. The submission describes what is required, which is one large facility and proper outreach arrangements to reflect the geography of an area. Both cannot be run. If they are duplicated, that simply means that making the transition, and the change is avoided. That is where we could see a major transition and change in how the system might look at the end of this period.

We think that a lot of those changes could be made in the planning cycle of this CSR. Not all of them could be done, because it is such an enormous task, but we think that we could be well through the process. To give you some idea of what that would mean in practical terms, in the primary care arena it means 21% more activity and work would be organised. That means

providing the necessary skills, expertise, ability and facilities to do that. It also means that there would be 15% more activity in community health, but it means a 7% reduction in hospitals, which equates to 350 beds across the Province. That is what the transition would mean; it would be that sort of shift from one place to the other.

We asked one or two questions about what would happen and what the impact would be if we found ourselves in a situation where we are continuing to make the changes but are not able to. Again, the McKinsey organisation indicated to us through its work that the "do nothing" option is not neutral and would have a cost, which McKinsey calculates to be £5 million a month. If we do not begin to address the problem and do not begin to look at the decisions, we will find ourselves spending £5 million a month inadvertently and inappropriately. We see all that sort of cost today in our locum expenditure and other sorts of expenditure. Therefore, I am sure that you can well understand where the £5 million figure comes from.

Having said all that, one has to ask how we would make a transition. The challenge is the offer of doing it and finding out how to do it. It is not terribly sophisticated; it is about proper and responsible project management and proper and responsible roles for all the various constituencies. I would triangulate that into three critical areas. First, there needs to be political support for making such changes; secondly, there needs to be professional agreement about the changes; and finally, we need to communicate the nature of the change responsibly to the population so that we do not make people think that a change, of itself, is a negative or bad thing.

That was a description of what we have been working on extensively over the past number of months. I am happy to take questions at this point.

The Chairperson:

Thank you, John. I have a couple of initial questions. How much did all the McKinsey work cost?

Dr McCormick:

It cost £330,000.

The Chairperson:

I am sure that you have read the transcript of Professor Normand's evidence to the Committee

where he suggested that improvements and efficiencies between 5% and 8% are possible in any budget of this size. We now have a suggestion that £0·6 billion could be saved, yet, in your opening statement, you said that the Minister has set his face against the changes. I know that you cannot answer for the Minister and I understand your predicament, but is it not a bit irresponsible, given that two separate authorities say that significant efficiencies can be obtained, for the Minister to say that he will simply not entertain the idea?

Dr McCormick:

It is important to finesse that slightly, if I may. The advice and analysis in the McKinsey work does not accept that cost improvement or efficiency change on a scale of 5% to 8% a year is possible. It sets a lower figure of more like 2·5% to 3% a year as the maximum possible, and even that depends on the acceptability of a lot of political changes. So, I will repeat what the Minister said. I will not answer your question or amplify that. He said that he sees some of the proposals as unacceptable, and it is a statement of fact that he will not implement them because most of what needs to happen here will need to be implemented and changed. If it is agreed politically, it will be subject to consideration by the next Executive and the next Minister, and decisions will have to be made as to what are the right things to do. That is still ahead for all of us. He has always said that there is room for more efficiency, and he has always talked about evolution and not revolution. The direction of travel needs to be clear and things need to be done in an orderly way that commands and sustains the confidence of the community, because that is, obviously, essential. However, the report says that major things are possible, especially those that relate to a very challenging budgetary context. The decisions lie ahead and are still to be taken.

Mr Paul Cummings (Health and Social Care Board):

The information with the written report looked at hospitals and systems from around the world, and the evidence shows that even in America, Canada and Germany, no system has been able to sustain over a four-year period the figures that Professor Normand has suggested. One system made 5% to 8% in a single year as a one-off but, over a period of four years, no system has achieved more than 3% to 4% each year. So, there is no evidence from around the world that suggests that we could save 8% year-on-year for four years.

The Chairperson:

You have basically told us that the Health Service will be almost bankrupt if it does not get an extra £200 million in cash at the start of the next financial year to meet the pressures. Yet, on

drug prescribing and procurement, which costs £148 million according to McKinsey, all we need to do is reduce the number of prescriptions per person by 12% to match the performance of England. That is just to match it, not beat it. Moreover, we need to reduce the cost per prescription by 25% to match top performance in England through generic and therapeutic substitutions. If my reading of that is right, it is not asking us to do anything that the authorities in England are not already delivering. That alone, in my reading, is £148 million. That is a long way towards achieving the extra cash that we need. I cannot see how it affects front line patient care if we are simply matching the performance of trusts in England. Have I read that wrong?

Mr Cummings:

The McKinsey report assumes that we make all those savings to get down to £4·8 billion. So, to get from £5·4 billion to £4·8 billion assumes that we become as efficient as the top quartile in the rest of the UK. However, in the figures, which are broad averages, there is no weighting for need. So, it is assuming the need of the population of Northern Ireland, and we have evidence that suggests that we need 16% more because of the current health status here. To get down from £5·4 billion to £4·8 billion, we have to deliver all of the savings that McKinsey has factored in, and the budget currently gives us only £4·6 billion. We have to deliver everything in those papers and then another £200 million.

The Chairperson:

If you were forced to deliver that, how would it affect front line patient care?

Mr Cummings:

To get to £4·8 billion, we would have to come up with a new model of healthcare with, as John said, less acute hospitals, less acute hospital beds and more patient care in the community. According to McKinsey, everything that John has suggested today must happen to deliver a budget of £4·8 billion.

Dr McCormick:

There are things that need to be done. The point that Paul made on prescribing is important. Reducing it to 12% matches the top performance in England, but the need of the Northern Ireland community suggests that a level of prescribing above the English norm would be appropriate. As Paul said, the evidence indicates that we have a greater need of between 7% and 16%. That is a challenge.

The generic prescribing programme remains. In the past few years, we have made very substantial progress on that, and there are plans to go further. The board is working on a further range of interventions that will increase the proportion of generic prescribing. Because new drugs are always coming along that are not off patent, there will always be a substantial proportion of prescriptions that are not generic. We are engaged to deliver those things, which are challenging. The figure of £148 million that is to be saved from generic prescribing is to be achieved over the four years. As Paul said, it will contribute to getting from £5·4 billion to £4·8 billion; it does not help us to get below £4·8 billion.

The Chairperson:

Much of your argument is predicated on your assumptions about demand and demographics. Professor Normand and his colleague were saying that those assumptions are exaggerated and that there are trends that are moving in our favour. One that I welcome is that the death rates for women and men are beginning to coalesce. Men are going to live as long as women, and everyone around this table, apart from the Committee Clerk, thinks that that is wonderful. Professor Normand was saying that that trend will, in itself, provide a cushion. He is also saying that the demand figures are extremely generous. It is the Department that has said that there will be an increase in demand.

Dr McCormick:

The point is that there is expert advice and evidence that is based on UK benchmarks that show that our calculations on demography and on residual demand are demonstrably broadly in line with practice elsewhere. Therefore, if we are getting it wrong, England is also getting it wrong. We do not accept that we are getting it wrong. The calculations are based on evidence and a full range of demographic factors, including the impact of the ageing population, not only on the acute sector but on community services and social care, and the birth rate. It would be great if Professor Normand were right, but we do not think that he is. We have examined the evidence and, fundamentally, we do not accept it.

Mr Compton:

The planning for the rest of the UK accepts the figures that we have presented, not those that Professor Normand presented.

The Chairperson:

Professor Normand also said that it is not the age of the population that counts but the proximity to death. In other words, an ageing population does not mean that people are more likely to drop dead.

Mr Cummings:

Professor Normand was assuming that our figures were for spending on acute services. We spend a lot on the acute sector in the last year of someone's life, but our demographic figures come from all programmes of care, not just the acute hospital sector. To keep in the community someone who is getting older requires significant investment in community services. Our demographic budget is not being spent only on the hospital sector; it is being spent across all programmes of care. Professor Normand also stated that he reckons that the cost will reduce because the male population will still have their wives alive to care for them. I see no evidence that spend will be reduced because men who need healthcare will get that from their partners rather than from the healthcare system.

The Chairperson:

He said that, in a house, you need a body and a head. In other words, you need someone who has the ability to look after someone who is ill. The propensity of Northern Ireland people to stay together in marriage or in a relationship means that a lot of care is being provided free of charge to the Department, because it is provided by close relatives rather than the Health Service.

Mr Compton:

It would be a quantum leap to base a future financial plan on that type of assertion. We have worked meticulously and in some detail with an organisation that has a pretty profound international reputation, and we looked right across a whole spectrum. We did not ask McKinsey to write something for us to give us an answer that we wanted. Rather, we asked for something that would inform the debate in a proper and responsible manner.

One of the reasons for proceeding in that manner was to avoid, as I said at the outset, the accusation of being partial, sectional or having some sort of constituency view of matters. It did not matter whether we were told that the figure was £4·4 billion or £6 billion. We may have had our views on that, but we wanted to see where that understanding sat across the piece, and we did not find any particular shocks. That is validated in some considerable detail across the UK, and

we will make that information available to anyone who wants to see it. The evidence is there, and it is for others to say that that evidence is incorrect. However, bluntly, I think that that would be difficult.

Ultimately, the debate starts with whether there is trust, and how much trust there is, in the figure of £5·4 billion. We feel that that figure is pretty accurate.

Dr McCormick:

It is also important to say that many costs arose because of the successes of healthcare in recent years. There are now more people living with long-term conditions. Part of the cost is for managing those conditions, and a big part of the change envisaged is the better management of long-term conditions. People are surviving longer with cancer and dementia, and there is a whole range of conditions that need continuous attention, which involves a cost. There is also a very important proportion of the population who live long in good health, which is tremendous.

We had to look at it using an evidence-based approach, and we believe that we thoroughly examined the evidence. We are doing our best to project forward; we are not trying to over-egg or overstate the issue. We are trying to give a fair and honest assessment of our concerns.

The Chairperson:

Just to clarify, the phrase that Professor Normand used was body and a brain, rather than a body and a head.

Mr Compton:

To reassure you, we take the pharmacy debate very seriously. In the year that is closing, the target for savings was some £40 million, and we are consulting with the pharmaceutical industry on a formulary and a whole range of major transitions that will transform our relationship with that industry. We are also involved with our primary care partnerships, and there are early signs of good progress, particular in western areas, where we are reducing the spend per person on standard prescriptions in a professionally agreed and managed way.

We take that whole issue very seriously, and it undoubtedly has a role to play in getting cash and containing demand. It is not as though we are saying that there is nothing in the pharmacy debate. It is very important, but one could not easily rely on it as the sole or substantive provider

of resource in the future.

The Chairperson:

I accept that it is part of a package, but if it were delivered up to the English levels, it would not, in the opinion of many, reduce front line patient care.

Mr Compton:

That is provided that you accept the need argument. There is a fundamental issue here, and you can either accept the conservative estimates that we are 7% more in need, or the more extreme level of 16% more in need, and adjust the numbers accordingly to reflect that. That erodes the ability to make the savings in the way in which it would normally be done. Of course we should look at what can be done without affecting what are sometimes described as front line services. This model is not an assault on front line staff; this model states that a number of things drive change. Quality of outcome is the big indicator, patient experience the second and then comes proper and responsible value for money. Those are put together to come up with the model and the estimated cost. That is a big challenge, a big ask, because it assumes that the total system is working in the top quartile. To get everybody in an organisation of the nature and scale of the health and social care system in Northern Ireland into that situation is a very big ask.

The Chairperson:

I accept what is a very deeply divisive political argument about the number of acute hospitals in Northern Ireland. It has probably been the most controversial issue in Northern Ireland since we have, sort of, settled the constitutional devolution issue. Only the threat to an acute hospital will bring 10,000 people onto the streets. That is a big and deeply difficult political decision that the next Minister, dear love him or her, will have to make. Let us park that difficult decision.

Mr McCallister:

Be careful in case it is you, Chairperson. *[Laughter.]*

The Chairperson:

However, if we assume that we have to stick with the present number of acute hospitals, McKinsey seems to indicate that better and more efficient use of those assets would potentially save £472 million. Reducing the average length of stay in hospitals would produce a saving of £167 million by 2014-15 and improving staff productivity would save £200 million. I know that

we have made improvements in length of stay. I accept that we put patients through hospital beds much more quickly than had been the case, but McKinsey seems to indicate that there is, potentially, £472 million in savings to be made by 2015.

Mr Compton:

I agree, but the difficulty is that we cannot be selective about one part of the report; it is a total package. To get that efficiency from the hospital sector, the model has to be changed. As I explained in the example that I gave of the chronic conditions, we have to provide two-and-a-half times the activity in the community or twice the activity, depending on the long-term condition. The only way to achieve that is to transfer the resource from one place to the other.

You are right: it is always alarmist to talk about closing hospitals, and people get upset by that notion. Therefore, there is an element of evolutionary change here. What goes on in buildings sometimes needs to change in a planned and responsible manner. However, the fact is that we have one acute hospital per 100,000 head of population, and nowhere in the UK is anywhere close to that ratio. Provision in the rest of the UK is about one acute hospital to 250,000 of the population.

Part of the reason people may say that we are inefficient is because we do not take the decision to reconfigure our hospital sector to permit it to be efficient. We maintain it in a status in which, by definition, it becomes inefficient. For example, if you run a small obstetric unit, that unit has to open 24 hours a day, seven days a week. The cost of staffing that unit, which delivers 800 to 1,000 babies a year, is not profoundly different to the cost of a unit that delivers 2,000 to 2,500 babies.

That is the ultimate efficiency argument and one that plays out all the way through. If we run emergency surgical departments that take in relatively small numbers of people, we must staff and organise it 365 days a year, 24/7. When you look at the volumes of activity versus the cost, you find the inefficiencies. That is where you find the lack of productivity and issues of length of stay. That cannot be addressed seriously unless a decision is made to reconfigure the hospital sector and, in parallel, change the model of community care.

Most people with chronic conditions do not want to go into hospital; they want to be supported at home. Because we have invested money in the hospital sector, our default position

is that that is the only service that we can offer. We have to get away from that and change the service, so we can support services in the community. That is what is referred to at the end of the report: 20% more in our primary care support; 15% or 16% more in our community nursing support; 7% or 8% less in our acute beds and changing the pattern and model of where those beds are. If we do not do that, we leave an inbuilt inefficiency. We cannot do what you are asking. You are asking each hospital to be a bit more efficient in its turnover and throughput. Part of the inefficiency is simply to do with the structural shape of it. Whether a hospital sees 2,000 admissions or 4,000, there is a cost. The ability to address that cost is difficult. Then there are quality issues on that top of that. This is not a debate about cash per se; it is more one of quality.

The Chairperson:

You know how difficult an issue that is. Every MLA will agree that there needs to be a reconfiguration of hospitals, provided it does not affect the hospital in their area. The view of most MLAs is that so long as it does not affect my hospital, I am happy that someone else takes it. The community will not accept a reduction in acute care in an existing hospital. It is a poison chalice for anyone who tries to deliver it. It is a hugely difficult political issue.

The McKinsey report indicates that, even if we are stuck with that model, some of which is historical, there are potential improvements in productivity, even within the existing structure.

Mr Compton:

No one will dispute that there is potential for efficiencies. However, we cannot solve the problem in a piecemeal manner. That is what the McKinsey report tells us. Remember, from £5·4 billion we are trying to work to £4·8 billion, which means the reshaping of hospitals, doing all the things with the pharmaceutical industry and all the things in the community. Having done that, we have a fighting chance, at £4·8 billion, of delivering care.

What is very difficult to do is to take one piece of the report but not another. That is a real problem for us. We have to commit to making the change. The change proposed in the McKinsey report is not the only kind we could pursue, but the direction of travel in the report is the right one. That would involve detailed work, which might mean that there would be more emphasis in one place than in another. That is perfectly reasonable. This is a direction of travel statement; it is not a detailed prescription of how to get there. We will have to have that debate. Ultimately, as I said, it requires a partnership involving a political system to accept and

understand that we need to make change properly and responsibly; a professional management system to explain that change; and a debate with the public to ask what they want. If we do not do that, to use your phrase, the issue of bankruptcy arises. Ultimately, then, people would be in a worse position.

The Chairperson:

I want to ask about the whole issue of social care. We have had evidence from the charitable and private sectors that they can deliver a much more efficient model than the state in some areas, such as psychiatric domiciliary care. Why does the Department seem to have set its face against that, given that many GB county councils are providing the same service, for a greatly reduced cost per patient, through the private sector? You have moved entirely to the private sector for nursing home care. It provides a service regulated by the Regulation and Quality Improvement Authority. If we decided to move that back into the state, we simply could not afford it. Why are we not following best practice from elsewhere in GB?

Mr Compton:

Again, it is a matter of debate and proportion. In some of the trust areas, up to 80% of the activity in domiciliary care is in the mixed economy, either through the voluntary or independent/private sector. There is a mixed package right across the whole Province.

There is a very strong incentive to work in that way. We are more than happy to work with any organisation delivering care, but it has to be to a particular level of quality and performance. When it is said — simplistically, I think — that the private sector can do that cheaper than us, it is sometimes correct and sometimes not. However, it is not accurate to say that we run all the services. We absolutely do not. A large range of organisations have contracts worth millions of pounds with us, providing all sorts of domiciliary and residential care. We are more than happy to see that responsibly move, and part of the whole social care change is targeted towards looking at how we deliver social care.

The more fundamental change in social care is not about who provides it; it is about giving the responsibility and the decision-making to the individual and to their family. They make decisions based on what makes their life work, rather than us turning up with a model of care and saying, "This is the only model and this is the only show in town as far as you are concerned." That is the more profound change, and that is what drives what you are hinting at, which is a different

alignment and a different way of doing things, where the individual works in partnership with the organisation to build a package of care, rather than receiving it because there is no alternative.

Dr McCormick:

I have two points. First, we discussed that issue with the voluntary sector since it was raised at the Committee and in discussions with the Department of Finance and Personnel on why greater use is not made of voluntary and community sector provision. The advantage is not there on a like-for-like comparison. Also, there are not that many voluntary sectors providers keen to expand their activities. Some are —

The Chairperson:

Nevin Ringland is claiming a 29% saving.

Mr Cummings:

Those figures are very dubious, Chairperson.

Dr McCormick:

They are not necessarily based on like-for-like comparisons. The vast majority of voluntary sector organisations are not saying that to us. We are hearing it from one or two but not from the vast majority. Obviously, we will want to keep that under review and look at all opportunities to proceed in the way that John said.

Secondly, a substantial issue is coming with regard to the long-term funding of elderly social care. A commission is examining the issue for the coalition Government, so new proposals will be emerging soon about the financing of such care in an English context. That will lead to interaction between what social care is provided by local authorities in England and how the benefits system is structured.

Issues will emerge that will cross the line between fully devolved functions such as social care and functions that are devolved but maintained in parity; that is, the benefits system. You will be aware from the issues that the Minister for Social Development has been handling that that is potentially very challenging and controversial territory. However, the Labour Government and the coalition Government recognised that the existing model of adult social care is simply not affordable in the long term. It is growing too fast, which goes back to the discussion on Professor

Normand. A major financial challenge is coming for which we will have to examine our own options and examine the implications of what comes out of the commission in England, because that is bound to interact with the benefits system.

Mr Gallagher:

Some things in the report provide food for thought but there are also things that seem to be of questionable value. You spoke about prescriptions and that is definitely an area with potential. John spoke of savings of £40 million already this year. We are near the end of the financial year; are we on target?

Mr Compton:

We are pretty much on target for that. We may not meet the full figure but we will meet the full figure next year because this started late in the year so we did not have the full 12 months at it. We are confident that that figure is deliverable. I do not have any difficulty with that. We are also confident that we will task the pharmacy side of the house to look very aggressively next year at where we are with potential savings. Those savings are about improving quality and making sure that we maintain our proper and responsible relationship with the pharmaceutical industry and the services to patients and clients. They are also about enabling us to respond to the introduction of new technologies and drugs. That is where we are with that.

Mr Gallagher:

On the questionable side, there is no mention in the report of, for example, out-of-hours services. It talks about moving to primary care, yet our primary care settings only open from nine to five on weekdays and cost between £21 million and £25 million a year. I would have thought that that had to come into this argument.

Another worrying issue is better use of estates. I assume that "reduce space per bed" means that if it is fine if a ward can be taken out of commission, but more beds should be put in an adjoining ward. I would not like to think that we were moving towards restricting space for patients or trying to put more beds into a certain unit of floor space. I would like your comments on that.

I believe that the future delivery of health here must be considered in an all-Ireland context. The report cost £330,000, yet it does not even recognise that there is potential for savings if we

were to approach some of the aspects of delivery in that way. The Belfast Trust was able to save £1 million a year over the next six years through one of its recent procurement exercises, yet the report does not look at that at all and simply refers to "fewer acute hospitals." That is disappointing. We should look at increasing the potential of some of our acute hospitals to deliver services to regions on the other side of the border.

Mr Compton:

You raised three issues. First, the new integrated centres that the report referred to would offer much more than the traditional nine to five arrangements. The expectation is that they would run over a much longer day to achieve that sort of efficiency. It we are to shift an extra 21% into primary care and 15% in nursing, it self-evidently follows that we will use those facilities in a much more expanded and expansive way across a longer day. That carries with it an inbuilt acknowledgement of the need to establish that efficiency.

I will need to come back to you on the specific issue that you highlighted in relation to beds. However, there is no expectation that another four beds will be crammed into a corner of a ward; that is not what the recommendation is about. Rather, it is about having the correct size and number of beds across the Province.

You also referred to the fact that the report does not mention an all-Ireland dimension, and to answer your question, I will return to what we asked McKinsey to do. We asked for some benchmarking and analysis, and for comparative data from like systems. As a result of the way that our systems are funded, those like systems are, in the first instance, those in Wales, Scotland and England. That is why all the information was taken from those systems, but that does not proscribe, prohibit or in any way suggest that we would not deal responsibly with delivering health in an all-Ireland context. We already do that, and we hope to continue to do so during this period. Indeed, where there are opportunities for both jurisdictions to benefit, it is sensible to do so. The main issue here is what is in the best interests of patients, and sometimes patients, particularly those who live in certain geographical areas, do not feel that a boundary is a boundary in their everyday lives. We work in that context and will continue to do so; there is no issue with that whatsoever.

Mr Brady:

The Chairperson already talked about the social care element, and your presentation to the

Committee states:

"Reduce unit cost of Adult social services - Home help and Care Home packages - could be through personal budgets, reducing the richness of packages and/or through assessment of needs taking DLA into account" .

Perhaps richness should be in inverted commas. It gives a figure of £111 million for that. In my experience, that is already happening across the board. You spoke about spreading the load across the system, but many aspects of domiciliary care have already been reduced.

Did McKinsey factor in the impending welfare reforms that are rapidly galloping towards us? For example, disability living allowance will change to the personal independence payment, which, by definition, will vastly reduce the number of people who qualify for it. As a result, that proposed saving may turn out to be a non-starter.

There is an issue with personal budgets, particularly for older people, and that will affect domiciliary care. We are dealing with the meanest pension system in the entire developed world. That needs to be put into context. Therefore, personal budgets are very difficult for a lot of people. We also have an acutely low take-up of pension credit of almost £2 million a week here for people aged 60 and over. I am not sure whether all that was factored in. You mentioned the commission that is looking at benefits, and I have no doubt that the coalition Government are looking at it in the context of reducing rather than improving. As has been said, welfare reform is cuts dressed up as reform. It is certainly not reform in the beneficial sense. We are talking about acute cuts, particularly for elderly people.

The Committee for Social Development was at a conference this morning organised by National Energy Action, and one issue that came out of that very clearly was the correlation between good heat and energy efficiency in the household. For instance, you may have come across a study in Easterhouse in Glasgow in which the blood pressure of people in two blocks of flats was measured. There was a huge improvement in the people who had energy efficiency measures done in their flats compared with the people who had not. The blood pressure of the people who had not had it done did not necessarily get worse, but there was a marked improvement in the other group. There was also an effect on the weights of babies of expectant mothers in houses that had proper heat. So, it seems to me that one thing that has to be looked at —

The Chairperson:

Is there a question coming?

Mr Brady:

Yes. Do you think that that should be looked at? That will not happen in this mandate but IT should happen in the next one. The likes of the Department for Social Development and the Health Department should address that. I sit on both Committees and I know that there is an obvious correlation. Is that being looked at?

Mr Compton:

The short answer to that is yes. It is in everybody's interest to have joined-up government so that decisions are taken between related Departments and there is a push towards an end point.

Mr Brady:

With respect, I have heard that phrase for the past four years, but the joining-up does not seem to be as joined up as it could or should be.

Mr Compton:

You are probably right. I do not think that anybody would pretend or protest that it is, by any stretch of the imagination, prolific.

Mr Brady:

One of my questions was about the factoring-in of the impending changes, because, if you mention benefits as an area that could be looked at to subsidise personal care packages, that will ultimately be affected.

The Chairperson:

It might not be as much as you would expect.

Mr Compton:

I will answer some of the specific questions. It did not take account of welfare reforms because the publication is old, so none of that work is factored into the McKinsey work. We must remember that McKinsey is not exhaustive. It was not meant to be all-embracing, covering every aspect of care. It was about broad directions of travel for how we deliver a health and social care

system and what sort of decisions we might need to take to do so. Clearly, the report says that we need a different way to deliver social care, and I do not think that anybody would necessarily dispute that.

One of the tremendous opportunities with changing the social care system is the social enterprise that will flow from it. For example, we can see how it might be very difficult for an older person who might not feel confident or comfortable with taking on all responsibility for organising their own care or support. However, with a local community development arrangement, we can see how that community can set up a social firm to look after and work with the elderly in its area. So, that is the direction of travel that is being pushed and supported as a good thing to do. Will changes in the benefits system ultimately have an impact on what happens in social care? They almost certainly will. Will that be positive or negative? To some extent, that will be depend on how that all unfolds. All this is saying, quite reasonably, is that if we continue to organise the way in which we deliver social care in the traditional model, we will have a problem.

Mr Brady:

You talked earlier about changing the system, but a change in the mindset is needed.

Mr Compton:

That is the point about the partnership arrangement. We need political buy-in, professional and managerial support and proper and responsible explanation to people who are receiving the service, so that we can assure people that if we spend £4·8 billion a year — if that is the number — on their health and social care, they will have a comprehensive health and social care system that will give them a very good outcome.

Mr Brady:

When someone goes into hospital, the consultant does not ask them how they got there. He is dealing the patient before him. He does not worry about the social care package or the domiciliary care. That is a part of the difficulty.

Mr Compton:

Again, that is referred to in the McKinsey work, as it looks at the areas for intervention, one of which is about prevention.

Mr Brady:

The public perception, particularly with regard to residential care, is that people are now a commodity and there is something to be made out of providing that care. However, going back 20 or 25 years, when we had residential care homes under the auspices of the trusts, there was a different perception. That also needs to be addressed.

Mr Gardiner:

This question is addressed to Mr Compton. In the Irish Republic, children who are residents pay for a visit to the doctor, medicine and hospital care. Have you any figures as to how many residents of the Irish Republic use our hospitals in Northern Ireland? How much do they pay?

Mr Compton:

I do not have information on that to hand.

Mr Gardiner:

Do any of you have that information?

Mr Cummings:

We do not have it with us.

Mr Gardiner:

Please research it and let me have it.

Mr Cummings:

Yes.

Mr Gardiner:

It is a figure that should come to the fore.

Mr Compton:

No payment is made by the individual when residents of the Irish Republic receive care in Northern Ireland.

Mr Gardiner:

Do they get care free up here in Northern Ireland?

The Chairperson:

Any EU citizen does.

Mr Brady:

There are reciprocal agreements within the European Union.

Mr Gardiner:

I thought that there was also a charge. Perhaps I have misunderstood that.

Mr Cummings:

No individual payments are made by EU nationals.

Mr Gardiner:

So, we get nothing back from anyone from another EU country who comes into our hospitals.

The Chairperson:

We would if we transferred someone up for, say, a cardiac bypass.

Mr Compton:

I take it that Mr Gardiner refers to ordinary, routine stuff. If someone comes up for a planned procedure that is contractually agreed before the procedure takes place, that is different. That does happen, both ways. We occasionally send people to Dublin, and Dublin will occasionally send people to us.

For example, the debate that was ongoing about the proposals for a radiotherapy centre is relevant. That debate is whether the cost should be for each case, or agreed by a block arrangement that would assume that a certain number of people will be sent in a given year and, therefore, for income security we will give a block grant. All of that is negotiated beforehand and will lead to cash transfers. However, if someone goes to a GP or an A&E because they have sprained an ankle or whatever, no one will ask them for payment and there will be no cost involved.

Mr Gardiner:

What about maternity services? Are they all free too?

Mr Compton:

That is correct.

Mr Givan:

On the back of that, if you have a road traffic accident in the Republic of Ireland and receive hospital treatment there, the bill will be sent to you. I am aware of that because I have received one.

Dr McCormick:

Because this is a matter for all EU relationships, a system of financial flows is managed by the Department of Health in London. When one goes on holiday, one should always take the little card that replaced the E111 form. If you need treatment abroad, you need to show your card. That triggers a system that leads to financial flows between member states. The financial flows on that basis, including the North/South flow in Ireland, are managed by the Department of Health in London. It is one of those things that should even out across the EU, because people travel in both directions.

From talking to my counterpart in London, I know that there is an issue there. The Department in London is carrying the cost of the specific flow that operates in the North/South context here. There is a flow, but it does not affect us. It neither benefits nor costs Northern Ireland public expenditure, because it is dealt with at EU level.

Mr Gardiner:

That is fine, as long as we are not losing money.

Dr McCormick:

I will look into that and get you more details on it.

Mr Gardiner:

Thank you.

Mr McCallister:

I would like to follow on from a point that Mickey made. John, you spoke about a preventative agenda. That is part of the debate that we have been having, given that over 1·6% of the budget goes into the Public Health Agency. I know that the direction of travel of the Minister's reforms has been very much about trying to move on to the preventative agenda.

You are working to a settlement, and you have been telling us consistently that £4·8 billion is the absolute rock bottom. That is even in the McKinsey report. If we went below that figure, it would be even more difficult to implement the sort of reforms that McKinsey is advocating or to do some of what the Minister has been doing with public health. It would get harder to move money from the acute side to that preventative agenda.

How do you see us managing that or even getting more from the acute to the preventative side in very difficult times? You will be aware of the links between health inequalities, housing, welfare and educational underachievement. Mickey Brady mentioned those issues, which is why I said that I was following on from his point. How do we get a mechanism in place so that we can address some of those issues in a much more cross-governmental, collective way?

Dr McCormick:

Joined-up government needs to improve seriously. The ministerial group on public health still exists and needs to be reinvigorated with the agenda. The Minister wanted to see that, which was one reason why public health was put at the heart of the RPA reforms. One reason for having the Public Health Agency was to promote that cross-working at a more local level. Part of that can be done across Departments. That is an element of what should be happening, because the social determinants of health are way beyond the scope of DHSSPS and our brief.

A lot depends on good housing, and the points about warm homes absolutely stand. Education and sport have a massive contribution to make. All those matter, and that is where ministerial and departmental involvement is important. Also important is what the PHA is trying to do at local level in building partnerships and promoting local authorities' work in that context. That work is significant, and it needs further invigoration.

If we do not make serious progress on that, the bills will simply increase, because the demand

will increase. It is far better to prevent, to secure early intervention and correction and to manage long-term conditions effectively in a community context. We have almost completed the procurement of the telemonitoring contract, which the Minister announced at the start of 2008. That is coming to fruition. It is a big and significant project that will help people to stay in their own homes and allow them to know that their health indicators are being monitored effectively and that they will get help if they need it.

A great deal can be done, but it requires fresh vigour and commitment in the health and social care sector. However, it also requires fresh emphasis and significantly better joined-up government. The Department for Social Development (DSD) is a major partner organisation, as are the Housing Executive and the whole education system. A lot can be done that will also be in the interests of those organisations. For example, better educational outcomes and better use of housing resources will be secured. Therefore, it is the right thing to do for government as a whole.

Mr McCallister:

It seems to be a remarkably hard place to get to.

Mr Compton:

It is a hard place to get to in a difficult financial environment. Specifically, however, we have to produce a commissioning plan. Whatever the Budget settlement is, we will be obliged to produce a commissioning plan that sets out the best that we can do with the resources that we have. We will have to set that out straightforwardly and honestly. We will do that in collaboration with our colleagues in the Public Health Agency, because that is what we are statutorily required to do. For the reasons that you pointed to, it is also the correct thing to do. We would be operating on an entirely false premise if we produced a plan that completely disregarded the whole preventative agenda. That is such an integral part of what we do, and it would be reflected in the commissioning plan. Depending on what the settlement amount is, there is no doubt that we will be able to spend only what we can. It will be what it will be, and the cloth will have to be cut on that basis. We will do that work jointly with the Public Health Agency.

Mr McCallister:

The history of looking at these things is that we tend always to go back and do the firefighting, because it has to be done. The public health side is sometimes an issue, even though we have the

collective will to work on it.

Mr Compton:

There is always a risk in such cases. Again, however, the way that we operate with the commissioning plan means that we will not drift into the easy trap of saying that we must do one thing and that we cannot do another. We will do what we can jointly and responsibly with the resources that we have. The delivery of health and social care is such a complicated thing that goes across a range of many services. We provide between 250 to 300 individual services every day across a range of circumstances. We also provide a preventative strategy that provides another 30 or 40 services. When we look at those 300 or so individual service lines that are running, we will have to do what we can with them, given the budgets that are available.

An interesting aspect of the McKinsey work is that it tells us that we should not fear change. We have made a lot of changes to our health and social care system, and we have done so successfully over the years. We can make the change, and we have the ability to do it. However, the challenge is in whether we are serious about wanting to make that change. If we do not, we will be at a crossroads, which will probably be driven by finance, although this is essentially an argument about quality. Finance is one of the agents that is firing the change in the middle of the process. As I said before, that is the issue for me. I would much prefer, first, that we were making changes that are driven by quality, with better outcomes for people, and, secondly, that we were taking decisions that are about cash control. There is a fundamental difference between looking at a problem and responding to it after it has been seen through different optics.

Mr McCallister:

The Health Service and the trusts are sometimes notoriously bad at selling that change on the ground. The Chairperson asked about managing change. Is this document a good template for starting the debate about the type of Health Service that we want and can afford?

Mr Compton:

Absolutely.

Mr McCallister:

Will it help us to configure and deliver the quality that we all want on whatever sites there may be, wherever they are and whoever the staff may be?

Mr Compton:

It is the trigger for a very serious debate for the political system, the population and the professionals and managers inside the health system. There is a need for an earnest debate about the subject. That will not be straightforward, as everyone at the Table knows. Those debates are always fraught and potentially full of contention. However, I do not think that we should be put off. If we look at how we used to run our cancer services and at how they are organised now, they are fundamentally different, and the outcomes are fundamentally better. There is a view, sometimes, that change per se is seen not as a good thing but as a bad thing. However, anyone who looks at some of the changes that we have made in the past 10 to 15 years will see that they have been good. For example, in domiciliary care, we support many more people in their own homes now than we ever used to. We support more people who are coming out of long-term institutional care from places such as Muckamore. That is all good, and we sometimes forget that change has happened and has happened successfully. We can successfully make the change, but it is not something that one party can do. Everyone will have to be agreeable to the nature of the change and to the fact that we need it, and they should join the debate about it.

The Chairperson:

Paul, we have to leave at 4.00 pm, so I think that there is time for one last question.

Mr Girvan:

Thank you very much for coming. I am encouraged to hear that you are willing to make change, because we have heard about modifications, and we have often heard that nothing can be done. We are hearing now that improvements in productivity can be achieved, so we are glad to see that there is a willingness to do that.

If I may hark back to a discussion that the Committee had before you arrived, I am worried that the current funding level means that we have had a 43% increase in some waiting lists. What has been done to allow that to drift in the budget, given that you already had the budget for this year? We know what we are trying to achieve over the next four years and to see where we can make savings.

However, the document makes little mention of something else that concerns me. I had occasion to spend quite a bit of time in a hospital over the past couple of weeks, and I had the

opportunity to go around some areas in the hospital complex that had been mothballed, and I use that term deliberately. Those areas were running with full heating on but were not being used as wards. That is unnecessary waste. There are people in the hospital whose job it is to supposedly manage. However, they are not doing that, because we can see it.

When will we see a proper audit of the resource, namely, the buildings and hardware? We are continually building, but some nurses are ultimately saying that that will not improve the delivery of service and that they were doing very well in some of the old wards. They say that it would be lovely to have nice new wards and so forth, but they ask whether that is a necessary spend. When I hear that, I think that I cannot make that judgement.

The Chairperson:

I ask you to give just one quick answer to that, folks, because time is running out fast. As you know, we have a public session in the Long Gallery later, and we have to get to that.

Dr McCormick:

The current year has been very difficult where waiting lists are concerned. There are issues to consider that are additional to the change that we made to independent sector provision. However, the big point about waiting lists is that the 2010-11 budget was affected by late reductions, which limited the capacity to deal with the lists. It is by no means totally a financial issue, but financial constraints in the current year added to the situation.

The use of space will improve if we carry out the reforms effectively. The report suggests that there is scope to do better on that, and that will involve looking very hard at our use of the estate.

Mr Compton:

I have a couple of short points to make. First, we made the 9% savings in the current CSR period, so the system has delivered savings. We judge the system by what it has done. So, if we have delivered the savings, that shows that we are capable of making them and that we are willing to do that.

Secondly, and on the specific issue that you raised, the casual circumstances that you described in that hospital are clearly wrong. No one would support that. However, I think that the issue is more to do with the capital and the buildings that we have. In some buildings, the

way that things such as heating systems are controlled makes it rather difficult to have the heating on in one part of the building and off in another. That is a sign of the conditions and age of the estate. The McKinsey report talks about a proper estate strategy.

I would say two things about the information that has been published today on waiting lists. First, the overwhelming majority of people are seen inside the waiting times of nine and 13 weeks. It is always a matter of regret if somebody is not seen. However, the overwhelming majority of people are.

We are in the middle of a transition between being reliant on the independent sector to having infrastructure at £25 million, with a second £25 million coming in. To speak in straightforward terms, the light cannot be switched on and off. It is a two-year thing; it takes us the two years to get all that in. Everyone thought that that was the best thing to do, so we are in the middle of that process.

There were particular problems in this quarter. As everybody knows, December was pretty difficult for everyone, not least ourselves. There was a very substantial increase in fracture cases, which required us to cancel some clinics. In December, we had over a 100% increase in people who did not attend their clinic. That is no criticism of anybody, because, as I recall, it was difficult in December to attend anywhere for lots of reasons. We had to stand some clinics down because we could not get staff.

December threw the last quarter into a difficult position. As we said at the end of the September quarter, we plateau on the way down. That is broadly where we are, even with the difficult December, and we expect further improvements for the March period in the middle of the transition. We also expect to get to a better place next year.

The Chairperson:

I have to stop the session at that point, because of our Long Gallery event. Thank you very much for coming. This may be your last appearance before the Committee, although I cannot promise that. If it is, thank you for your help over the past few months.