Committee for Finance and Personnel

OFFICIAL REPORT (Hansard)

Review of the Efficiency Delivery Programme: DHSSPS Briefing

8 May 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Daithí McKay (Chairperson)
Mr Dominic Bradley (Deputy Chairperson)
Mrs Judith Cochrane
Mr Leslie Cree
Mr Paul Girvan
Mr John McCallister
Mr David McIlveen
Mr Mitchel McLaughlin
Mr Adrian McQuillan
Mr Peter Weir

Witnesses:

Mr Paul Gibson	Department of Health, Social Services and Public Safety
Ms Julie Thompson	Department of Health, Social Services and Public Safety

The Chairperson: I welcome to the meeting Julie Thompson, the undersecretary of resources and performance management in the Department of Health, Social Services and Public Safety (DHSSPS), and Paul Gibson from the financial planning unit. We will go straight into questions.

Judging by the Audit Office report, the efficiency delivery programme has been a bit of mixed bag for the health service. There are some very good case studies. The maximising outcomes, resources and efficiencies (MORE) programme is highlighted, as is some work in the trusts. The report refers to pharmacy procurement and the £6·6 million that was saved in that area. However, there are also concerns in the report. At a previous session, we discussed case study 4 on the Northern Health and Social Care Trust. It refers to the closure of 28 beds at Whiteabbey and Holywell hospitals. It states that neither the Department nor the trust knew whether there were savings as a result of closing those 28 beds. That is pretty stark. Would you care to comment on that?

Ms Julie Thompson (Department of Health, Social Services and Public Safety): I am happy to do so. As regards savings and the way in which the Audit Office went about its report, it looked for prescriptive information and actual evidence to be collected on each individual savings proposal. It was looking for baselining information being in place, by which you then tracked what actually happened through the system. What the Audit Office said against that was that a baseline was kept of expenditure for that area and that the tracking of what happened to patients and the working through in quality maintenance is where insufficient information was available. Impact and quality of care was, therefore, difficult to establish. That is because, when we work with trusts, a lot of work is carried out at a global level on the trusts' performance management and quality of care rather than monitoring individual savings proposals at that level, which the Audit Office suggested was necessary. So, on

that proposal, the issue was the depth of information that the Audit Office was looking for rather than what we look at globally across the piece with the trusts.

The Chairperson: If there were cases such as that in the future, would you change your approach?

Ms Thompson: That was one of the difficult areas. The report mentions the complexities of the health sector and how you can manage a lot of individual proposals and a lot of things that are happening at the same time in the sector, of which a savings proposal is one part. I agree that we can attempt to identify information on individual proposals more closely. However, you also have to recognise the entire gamut of changes that are happening throughout the health sector and the level of prescriptiveness that the Audit Office was looking for, proposal by proposal and separately identified. In the health service, it is difficult to get information on one proposal only because you are looking across the piece at changes in a wider dynamic. It recognised that.

The Chairperson: Was the Audit Office —

Ms Thompson: To be fair to the Audit Office, it recognised that and the particular complexities of the health sector. The report refers to the need to look at multiple indicators to establish, for example, what is happening and whether it is not as simple as monitoring one thing; you have to monitor across the piece. However, the more things that you monitor and the more global that is, the less specific you tend to be. That is where the balance is.

The Chairperson: Do you think that the Audit Office was too prescriptive in its initial approach?

Ms Thompson: No; I would suggest that the Audit Office has followed a particular line. In the second section of the report, it recognises that the health sector is complex, and it refers to the tracking of inputs to outputs being complex. The Audit Office followed a right and proper approach. It is simply difficult to apply it in the health sector in a rigid sense because so much is going on.

The Chairperson: What is your view on the departmental guidance from the Department of Finance and Personnel (DFP)? Was it appropriate at the time for the period?

Ms Thompson: The guidance came from the original comprehensive spending review (CSR) from Whitehall at the time, and that was shared with Departments. It laid out what we needed to do, and we set out to do that as best we could. Like everything, you can learn, and equally, the efficiency agenda has become even more challenging, hence DFP is putting the onus firmly on Departments to manage those efficiencies effectively and ensure that Ministers are content with what is happening. The guidance has been refined over time, and it now has a similar base to the original guidance. Was it fit for purpose? Yes, it was fit for purpose, but there has been ongoing refinement.

The Chairperson: Are you happy with the present guidance?

Ms Thompson: The role of guidance is to set the scene and the format of what is required. Given that the sectors are all so different, we need to understand how that applies in individual sectors. It is difficult to get guidance that suits everyone.

The Chairperson: Are you happy with it in the Department of Health?

Ms Thompson: We have managed it and worked with it as best we can.

The Chairperson: Did the DFP supply officers, with their challenge responsibilities, raise with you any of the concerns about the efficiency measures that the Audit Office highlighted in its report?

Ms Thompson: There were discussions with DFP at that time, informal liaison with our supply officers and formal reporting on a six-monthly basis. You are going back in time, but I cannot recall whether they specifically raised any of the individual issues that the Audit Office pointed out. However, there were certainly ongoing discussions about our efficiency plans. We delivered our efficiency targets and, in monitoring that, more concern was raised about efficiency targets that would potentially not be met. I cannot be definitive about whether they queried individual proposals. A lot of that was being managed in Departments to ensure that Departments were doing more detailed monitoring.

The Chairperson: Can you provide us with a written response on that query?

Ms Thompson: I can.

Mr D Bradley: Good morning. You said that, from your level, you take a global view of efficiencies across the health service and that you may not be across the detail of some of the individual proposals. With a proposal similar to the one mentioned by the Chair, when 28 beds are being closed in relatively small hospitals, you should surely sit up, pay attention, ask more questions, monitor the effect of that and see the impact on front line services, except that you cannot monitor every individual proposal. Surely you should have some system or mechanism to scrutinise in more detail the proposals that have the potential to impact on front line services than you do with some lesser proposals.

Ms Thompson: When I responded to the Chairperson, it was about our performance management mechanisms, which tend to be on a global basis.

I will pick up on your point about the efficiency proposals and explain what happened at that time. We gave out targets to the individual trusts and to all our bodies. They then had to produce plans about how they would deliver to those targets.

You are quite right: the proposals were spelled out in those plans, and there were discussions about the impacts of those proposals on patients, clients and staff. There is a need to ensure that issues such as procurement and management costs, and so on, were appropriately featured in efficiency plans.

I would not like to create the impression that we did not look at individual savings plans. There was a return to the Department about individual savings proposals. The issue that I was reflecting to the Chairperson was about tracking on through the process and ensuring that the quality of care for those patients, two, three, four and five years down the line, was still being maintained. At that point, in the health sector, it shifts into a more global measurement of whether we are delivering against the targets in our commissioning plan direction. We have a range of quality and safety metrics on how quality is managed. The ongoing monitoring of the service is done on a global basis.

You are quite right; proposals were looked at individually before they were put into place.

Mr D Bradley: Is there any direction to flag up the proposals that could be controversial and have the potential to create public unease about the impact that they might have on front line services?

Ms Thompson: In the time covered by the report and the CSR process that we worked through, we looked at the proposals from the trusts. There was significant engagement, for example, through the Health Committee, with us about our savings proposals, and there was a lot of interest in them, as you would expect. There was liaison between the Department and the trusts about that.

At that time of the report, however, we were going through a period of organisational change, and the review of public administration (RPA) process was happening. The new trust mergers took place in 2007, and the regional bodies were created alongside the board mergers in 2009. A lot of other things were happening in the health service at the time covered by the report.

Mr D Bradley: I focused on that in particular because I have seen examples of beds being closed, and when there is a spike in illness, as there is every winter, there are insufficient beds to accommodate patients, and emergency departments are used as wards, which has a knock-on effect. That shows the absolute necessity of tracking the impact of these proposals and ensuring that they are improving the system rather than disimproving it.

Ms Thompson: With the bed situation, a lot of evidence and statistics on length of stay show that services should be provided as day cases rather than through an inpatient stay. In that model, patients would be admitted on the day of surgery rather than pre-surgery.

We are marrying analysis of best practice and clinical practice with a measurement of the impact and sustainability of that approach, particularly at difficult times of the year. That is the challenge faced by all the trusts in ensuring that what they are doing is managed, manageable and can be sustained. At times, that can be very difficult and challenging.

Savings that have been coming out cumulatively, as they have been, has meant that things become even more challenging further on. That does not mean that we should stop looking for benchmarks for improving performance. Equally, as I said, we also need to look at issues such as procurement and management costs. So much of our service is spent on the front line that we have to find ways to make that as efficient and sustainable as we can.

Mr D Bradley: The Department of Finance has said that the efficiency agenda will be delivered trans-departmentally in the future, which will entail quite a bit of collaboration between Departments. How will the Health Department collaborate with other Departments to achieve efficiencies?

Ms Thompson: Procurement is a good example. We already have a regional procurement service for the health sector that we are proactively managing to ensure collaboration within the health agenda. That needs to be broadened out through liaison with our procurement service and the global services in other Departments and across the Northern Ireland Civil Service (NICS), and that will be ongoing. Another example is in the world of asset management: the asset management unit wants Departments to manage their capital assets more effectively for the greater good of the public sector. We are still working through the journey in the health sector: for example, we are implementing our shared services model for our back-office functions. We would strongly pursue that agenda in the health sector and then look at the wider view.

Mr D Bradley: You said that you do procurement on a regional basis. Is that within Northern Ireland or further afield?

Ms Thompson: A procurement service is set up in the Business Services Organisation that looks at procurement for Northern Ireland, but it also looks at frameworks from across the water and NHS supply chain work. It has the expertise to see where things can and should be done locally and where there is a benefit to be gained from looking wider. The collaboration on procurement is firmly in place in the health sector, and we also look to see how we can utilise other frameworks. It has to be done in line with legislation and procurement regulations; it is a complex area.

Mr Mitchel McLaughlin: Thank you very much. There were a number of positive examples in the Audit Office's report as well as some disappointing outputs and variances between the performance of one trust over another. Is pharmaceuticals procurement now mainstreamed in the health service regionally? Is every trust signed up for it?

Ms Thompson: A lot of the regional procurement initiatives are in primary and secondary care, and it is still a strong area. We have to ensure that we are maximising across the region in that area.

Mr Mitchel McLaughlin: Sorry; is that yes or no?

Ms Thompson: It is a yes; absolutely it is a yes. It is mainstream, but it has also been given a separate focus so there is an element of that still in place.

Mr Mitchel McLaughlin: I am trying to make up my mind whether it is a yes or a no. It does not sound as if it is a yes.

Ms Thompson: It is mainstreamed in the sense that it is very much a part of how we do our business. Therefore, to my mind, it is mainstreamed. That does not mean to say that you do not need to still focus on it. You need to focus on it, and it is still part of how we do business; that is where I am coming from.

Mr Mitchel McLaughlin: A concept is developed, which is proven to work in one trust area; it has been road-tested and is effective. Why is it not formally adopted as a matter of policy across all the trusts?

Ms Thompson: That is where we want to get to. As far as the regional procurement initiative is concerned, it has been rolled out and is right across Northern Ireland. In answer to your specific question, that one is definitely in place. I think that you have a general point, which is around how we ensure that that happens in all our efficiency proposals. We work with the Health and Social Care Board (HSCB), which works above the trusts. We do that to ensure that it is ensuring that best practice is being shared across trusts, that learning is going on and that, if one trust has a good idea and a good proposal, it is being worked into other areas. Trusts share proposals with one another to

understand what they can potentially do. The procurement piece has gone widespread across Northern Ireland.

Mr Mitchel McLaughlin: If we were to ask for an analysis across all the trusts, you could demonstrate that the savings that were established and proven in the South Eastern Trust were being applied across the piece. Presumably, that at least produced the equivalent in savings and possibly even exponentially increased it because of the greater critical mass in purchasing power. We had examples of the reduction in unit costs for specific drugs, and we have had an ongoing issue with generic, or otherwise, and resistance to the appropriate quality of drugs but at the lowest unit cost. There seemed to be resistance in the system; people had preferences, and so on. Have we overcome all those cultural barriers to achieving the best buy for the pound?

Ms Thompson: Pharmacy still features heavily in our plans. Our generic prescribing rates have increased significantly. I do not have the figures with me today, but I know that they have increased significantly since 2007. There is significant focus on that area to ensure that people get the best bang for their buck and that the right drugs are being applied consistently. It is still there. I cannot say that we have done everything because we have not; there is still more to be done. There is a focus to drive out ever more savings in that area, but a significant amount of money has been taken out of pharmacy over the past five or six years, and we can provide that to the Committee if that would be helpful.

Mr Mitchel McLaughlin: Does the regional pharmacy group oversee that entire procurement process across all the trusts to ensure that there is consistency, that they are maximising their leverage on the market and that they are purchasing the appropriate quality of drugs for the best price?

Ms Thompson: We have two angles. There is a regional understanding across the secondary care setting about what is going on in trusts to prescribe drugs. Equally, there is a focus in the primary care setting, where a lot of the prescriptions are made. We have both tracks to ensure that pharmacy is given a significant focus and continues to be a big contributor.

Mr Mitchel McLaughlin: I am using this only as an exemplar, but why would there be any difference or distinction between primary care and secondary care in the purchase of appropriate medicines or drugs?

Ms Thompson: You are dealing with GPs in one set-up and the trusts in the other. We have mechanisms whereby there is liaison. We manage and look at the level of generic prescribing in individual GP practices. That is managed by the board, which does a lot of work. There are pharmacy advisers in the board who work with GPs to ensure that there is learning and that things are being managed appropriately. We also work with secondary care consultants and clinicians about what is happening in that sector. Transition is a big issue. How do you manage and ensure that people who leave hospital have drugs appropriate to their needs at home and that there is clarity of transition into and out of the hospital sector? There is a focus on that work to ensure that that happens as efficiently as possible and that drugs are not left on one side or the other. Those areas have received attention to ensure that those transitions happen appropriately.

Mr Mitchel McLaughlin: I understand that it is complex, and I am not going to labour this example. The reason why I wanted to talk about that unified approach is to ask whether you have identified other areas in which financial resources are necessary to support the service and in which a centralised or regionalised approach is now being applied as a result of the lessons learned. I am not entirely reassured that we have a joined-up approach. It seems to me that there is a significant culture of fiefdoms, and people do their own thing. People are possibly prevailed on to see the necessity of a more co-ordinated approach, and then, over time, revert to doing their own thing when everyone is busy doing other things.

I will cut to the chase. Have you identified, at a central level, other areas of expenditure that can benefit from that regionalised approach? Have you taken steps to achieve those efficiencies?

Ms Thompson: In the world of procurement, the goods and supplies going into the system are looked at on an ongoing basis. There was a big procurement exercise for bandages, dressings, and so on, to make sure that such purchases are being done more effectively regionally. That may sound like a very small area, but the spend mounts up. As I described, we are looking at our back-office functions and trying to bring those together into a global shared services arrangement to improve efficiency. We

have done a lot of work on procurement, and we continue to focus the regional procurement body on ensuring that there is learning across the piece.

It is, however, broader than that. It is about how any trust proposal is shared across the trusts and that there is value in it. I described how best practice on length of stay, day case rates, and so on, is learned and understood by the trusts to the extent that they can operate with those models. The heart of your question is: is appropriate benchmarking in place, and are there mechanisms to ensure that that learning is shared? The significant role of the board is to do exactly that: to ensure that benchmarks are in place and that people learn from them, and that proposals are not identified and put in place in one place but not copied across the trusts.

Mr Mitchel McLaughlin: What if I were to ask for a list of projects that are regionalised — genuinely, comprehensively regionalised? We have identified staple elements of the health service provision and the significant savings that could accrue from a more centralised purchasing arrangement. They are then distributed, in implementation and delivery, through the trusts and down through the agencies, the secondary care sector, and so on. Could you give me such a list? You were describing a lot of conceptual ideas.

Ms Thompson: We have lists of procurement contracts that are done on a regional basis and are all aimed at driving out best value for money. On the pharmacy side, demonstrable savings are coming through on that budget, year on year. Those are all shareable with respect to the amount of money that has come out of the pharmacy budget. A large portion of that has come out as a result of better management of drugs regionally, and ensuring that things are being procured as efficiently as possible and being prescribed in a way that is as efficient as possible. We have a whole host of those. The Health Committee has looked at the area of progress on the pharmacy budget over the past five or six years. There is a significant positive trend.

Mr Mitchel McLaughlin: To help the Committee in its review, you could give us a list of projects. I do not know how many there are, but we would hope to see as many as possible where you can demonstrate that unit cost savings have been achieved.

Ms Thompson: I can give you a list of our regional procurement contracts and an assurance that those have been put in place across the Province. Each of them is led by what comes out of a tender and what we get back from suppliers. If it is helpful, I can certainly provide the Committee with the list of contracts that are done on a regional basis. There are a significant number.

Mr Mitchel McLaughlin: Maybe you could extend that across different aspects of the service: for example, the energy costs incurred, which must be horrendous. Energy must be fairly expensive in these economic circumstances.

I would like the widest possible example of how the concept of driving down unit costs is being applied in the health service and driven out through the entire piece, to use your favourite expression.

Mr Cree: That was quite a wide-ranging discussion. I am particularly interested in whether you can measure effectively. Do you have a robust baseline in place across all sectors so that, when any savings delivery plan is approved, you can commence to measure it effectively? Do you have your unit costs, and so on, in place so that you can demonstrate what you have saved?

Ms Thompson: The lack of baselines is a criticism of health service projects in the report. Some baselines were not in place, as the Audit Office pointed out. As the report recognised, that was largely because of the organisational change going on at the time. Effectively, we were looking for a baseline that was coming from multiple organisations and merging into one. Therefore, it is easier now, with bigger trusts, to establish the baseline in an area and then to know whether and how you are moving forward from that baseline. So the answer to your question is that we are better now, but the criticisms in the report are fair. At the time —

Mr Cree: I accept that.

Ms Thompson: — we struggled with some of that. We need to get better at it.

Mr Cree: Is everything OK now and in place so that you have no doubts about genuine efficiencies?

Ms Thompson: I would say that things are better now.

Mr Cree: You say that —

The Chairperson: How much better?

Ms Thompson: Does it mean that everything is perfect? I could not possibly say that. We are certainly better now than we were. We rely on information coming through and being captured at an appropriate level in trusts. We do not want to create an overly bureaucratic process either, which would mean going down to such a level of detail that we would be tracking multiple strands. There is a balance to be struck in how much detail the proposals should go into. I accept what the report said.

Mr Cree: I have two quick questions on areas that caught my eye and which I found rather interesting. One was to do with the review of public administration. Your Department is probably one of the few that achieved that, so it is disappointing to read that you could not prove that doing so was an efficiency saving.

Ms Thompson: We could prove the savings that came out of the RPA, and we knew how much it cost. Also, as the report sets out, for each member of staff who left the system, the payback period had to be justified, and all of that was tracked. Changes were ongoing, so this goes back to the issue raised earlier: you never stand still. It is not possible to say, "We will change only a particular bit of the system, track that and ignore everything else that is going on." That is where the Audit Office struggled because, in the meantime, the world moves on. We know what happened at the time. We know that 1,700 posts came out through the RPA. However, in the meantime, other changes were ongoing in management and administration, as you would expect. The Audit Office said that it was difficult to understand exactly what was going on in that area. The savings that materialised were driven by individual business cases on a person-by-person basis. There was a lot of scrutiny of that at the time. People left the system, but the world did not stop.

Mr Cree: The world was not expected to stop. The world, I hope, will continue. You still have to monitor your savings. Do you have adequate monitoring facilities now?

Ms Thompson: It comes back to the question of balance: we monitor the savings that the trusts deliver monthly. The HSCB monitors that with the trusts and provides that information to the Department. There is an issue with the level of detail that the Audit Office is looking for. Proposal by proposal, I would suggest that, even now, we would struggle to get the level of detail stipulated in the report. We are better at the baseline side of the piece than we were. This goes back to where we started the discussion, which is the monitoring of quality and performance management, and that tends to be done on a more global basis than through following individual proposals.

Mr Cree: By "global", do you mean Northern Ireland?

Ms Thompson: No, trust by trust.

Mr Cree: I will ask this question of Paul because he has not yet had a chance to speak: how do you reckon that the introduction and increase of car parking charges is an efficiency saving?

Mr Paul Gibson (Department of Health, Social Services and Public Safety): The DFP guidance states that income generation can be recognised as an efficiency saving.

Mr Cree: As simple as that?

Mr Gibson: Yes.

The Chairperson: Is that still in the guidelines?

Mr Cree: It is not in the current ones as far as I know.

Mr Gibson: I am not too sure; I would have to check that for you.

The Chairperson: The guidelines have been amended since then.

Leslie made the point about having a baseline. Do we have an appropriate baseline in shared services?

Ms Thompson: Yes, baselines were captured in the business case for shared services and will continue to be monitored through the implementation process.

The Chairperson: What kind of efficiencies?

Ms Thompson: Over a 10-year period, there were to be approximately £120 million of savings, if I recall the figure correctly.

The Chairperson: How are we doing?

Ms Thompson: We are still implementing. *[Laughter.]* When in implementation mode, a lot of focus goes on putting the systems in place. Those are not yet fully in place in the trusts, so it would be most inappropriate to talk about savings coming out the other end because we are not at that stage yet.

Mr Mitchel McLaughlin: Somewhere between £1 million and £120 million.

Ms Thompson: We have to work it through.

Mr McQuillan: I am a wee bit confused about the difference between what the HSCB and the trusts are supposed to do. You said that the HSCB monitors the trusts' efficiency. Who monitors the HSCB?

Ms Thompson: The Department.

Mr McQuillan: Will you explain how the HSCB monitors the trusts?

Ms Thompson: I am describing the system as it is now as opposed to how it was when the report was put together. The HSCB is responsible for commissioning services from the trusts — buying what it believes is necessary to meet the need. It is then responsible for performance-managing that and ensuring that trusts are delivering and meeting targets. It is also responsible for managing the financial aspects of trusts' performance. We then hold the board to account to ensure that all of that has happened and that the service will break even. We monitor how the savings proposals and efficiencies are going. The HSCB has the primacy role with the trusts and works directly with them, and we then deal with the HSCB on that.

Mr McQuillan: Westminster thought it essential to have a centralised co-ordinating body to challenge Departments on efficiencies. Do you see the need for such a role here?

Ms Thompson: For me, that goes back to Mitchel's point about ensuring that we constantly develop and learn from best practice. That may be a challenge function or a need to reach out and ensure that we are aware of best practice and put it in place. The HSCB is expected to ensure that any best practice is spread across Northern Ireland, as I explained. Part of that role is challenging trusts and ensuring that they are doing the right things and that good practice in one area is reflected in another. However, it cannot just be about what is happening in Northern Ireland; there must be learning from other sectors and other places. We have worked with the UK Department of Health, for example, to understand its processes and how it has been looking at savings proposals and then bringing that back here. The service has a different set-up here, with the integration of social care, but there is a need to ensure that there is a learning process and a sharing of best practice. I agree with that. How it happens is a different story.

The Chairperson: OK, members. There are no more questions. Thank you very much, Julie and Paul.