Northern Ireland
Assembly

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Evidence Session with Trade Union Representatives on the Comprehensive Spending Review

8 October 2009

NORTHERN IRELAND ASSEMBLY

_____

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

_____

Evidence Session with Trade Union Representatives on the Comprehensive Spending Review

_____

8 October 2009

Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Dr Kieran Deeny
Mr Alex Easton
Mr Sam Gardiner
Mrs Carmel Hanna
Mrs Dolores Kelly
Mr John McCallister
Mrs Claire McGill
Ms Sue Ramsey
Mrs Iris Robinson

Witnesses:

Mrs Lily Kerr	) Irish Congress of Trade Unions
Mr Kevin McAdam	) Unite
Mr Kevin McCabe	) Northern Ireland Public Service Alliance
Ms Patricia McKeown	) UNISON

The Chairperson (Mr Wells):

I welcome Lily Kerr, chairperson of the Irish Congress of Trade Unions (ICTU) health services committee, Kevin McAdam, the regional officer of Unite, Kevin McCabe, the joint secretary of the health and social care (HSC) trade union, and Patricia McKeown, the regional secretary of

UNISON.

Given the considerable interest inside the room and much further afield in what the witnesses have to say, I want to leave the maximum opportunity for questions. Therefore, I suggest that witnesses keep their opening comments brief because they will have the chance to expand on them as they answer numerous questions. I will try to finish the session in one hour, so I ask the witnesses to allot three to five minutes for their opening statements and then use their answers to expand on the information.

Mrs D Kelly:

Will the Committee be hearing from representatives from the Royal College of Nursing (RCN) and the Allied Health Professions Federation, or will one of the witnesses represent them?

Ms Patricia McKeown (UNISON):

I will set that out. Thank you for the opportunity to address the Committee. Members probably know that we sought a meeting before the summer recess, but that was not possible. However, since then, we have had a range of meetings with the Minister of Health, Social Services and Public Safety and with some of the trusts' chief executives. Our common view is that there is a very big problem here that we have to confront.

Our grouping intends to use the 10 to 15 minutes available to us collectively. We have three people who intend to speak, not four. RCN members are present in the Public Gallery. We will use our time as effectively as we can, but we must give the Committee an overview and suggest some strategic solutions to the problem, after which we want to engage with members.

To clarify the nature of our organisations: I represent UNISON, which is the largest union in the Health Service; my colleague Lily Kerr represents the Irish Congress of Trade Unions and is the chairperson of its health services group, which represents all the congress unions, both private and public sector; my colleague Kevin McAdam will address the Committee on behalf of the Health Service negotiating unions, which include the Royal Colleges. We also have Kevin McCabe from the Northern Ireland Public Service Alliance (NIPSA) and Janice Smyth of the RCN, who are also joint secretaries of that negotiating group. Today we speak with one voice. I invite Lily Kerr to present an overview on behalf of the congress.

Mrs Lily Kerr (Irish Congress of Trade Unions):

I will endeavour to meet your demand, Chairperson, to be swift, even if that means going like the clappers. As well as being the chair of ICTU, I am the lead joint secretary of the negotiating unions within health.

Mrs Hanna:

May we have a copy of the presentation?

Mrs Kerr:

I am sorry, I do not have copies. I can leave my copy with you.

Mrs Hanna:

It is very difficult to ask questions without a copy of the presentation.

Mrs Kerr:

You can send someone to have it copied, but that will hold up the meeting.

The Chairperson:

One of the Committee staff can do that. Does that leave you without your notes?

Mrs Kerr:

It does. That is why I made the point that making a copy will hold up proceedings.

The Chairperson:

I am sorry; I thought that you had copies.

Mrs Kerr:

We do not.

The Chairperson:

You cannot start your presentation without your notes.

Mrs Kerr:

That is what I was trying to say.

The Chairperson:

In future, it would be very helpful if you could provide copies of your presentations. The Committee has made several requests for copies. On such an important issue, not to have a copy of the material, at least a day before the meeting, puts the Committee at a disadvantage.

Mrs Kerr:

Your points are noted. I will say to you that all of us were extremely busy, as you may have noticed, over the past few days. Things are moving at quite a pace.

We are experiencing the most critical time for public services for the past 30 years. Unfortunately, throughout the past year, and, most importantly, particularly within the last three months, we have witnessed our predictions come true. More than two years ago, the trade unions made keynote submissions to the Northern Ireland Executive on the Programme for Government and the Budget. We warned of the consequences of demoting health and social services as the number one priority. We also highlighted the problems that they would face in education and housing. The unions strongly advocated top-level political backing for the equality duty and a statutory anti-poverty plan. We took our campaign to all Ministers, all political parties and all public service decision-makers. With the exception of the Minister of Health, Social Services and Public Safety, we were ignored.

As our members now know only too well, the crisis has hit us. Front-line jobs in health, social care and education are being cut daily. Plans are being implemented to shed thousands of jobs in the public sector, and almost 60,000 jobs have been lost in the private sector. Professor Richard Barnett has analysed the Executive's economic strategy and concluded that public money was wasted. Invest NI alone has wasted £1 billion. That money was removed from the health budget, the education budget and the housing budget. The only new jobs created are low-paid jobs and casual employment. Most jobs have gone to multinationals and profitable local companies. Jobs have not been created where they are most needed.

Using the Joseph Rowntree Foundation minimum income standard, we see that 50% of the population does not have a living wage. Our poor health inequalities record has not changed. The gap between the rich and the poor has widened. The equality duty has not been applied, and no connection was made by the Government around the vital link between social and economic health. We are witnessing a return to casualised and agency work, while thousands of public

sector jobs are held vacant. We are facing a pattern of school closures and closures in the Health Service, while billions of pounds are being wasted on a failed economic strategy. At the time that we need equality most, there is increased blocking and misuse of the equality duty.

ICTU backs the call for the exemption of the Health Service from efficiency savings, the comprehensive spending review (CSR) and all cuts that follow from that. Our Health Service is massively underfunded. The gaps between money available and needs include a 17% deficit in care in the acute sector, according to the Department of Health, Social Services and Public Safety's (DHSSPS) figures; a 30% deficit in services to children, including health and social care, according to the Children's Commissioner's figures; a 35% deficit in primary care, including mental health, according to DHSSPS figures. Those figures are a disgrace. They indicate a disastrous legacy from direct rule. Health outcomes are radically unequal, and poverty still scars our lives and leads to premature deaths. The statistics of inequality have not improved for 10 years, according to the Chief Medical Officer's evidence to the Committee. Funding is, therefore, fragile.

The process that led to the Programme for Government put growth and prosperity before health. There was a baseline of only £100 million in 2007-08 to fund new work, including cross-infection, strategies to reduce taking life and the needs of children exiting care. To make the figures add up, health bodies, including the trusts, have to save 3% in 2009-2010 and 4·5% in 2010-11. Failure to do that will lead to cuts in the care budgets because trusts are required to break even each year.

There are some savings that can be achieved without harm. For example, replacing prescription drugs with generics is one example, although I believe that that was well milked under direct rule. The sorting out of legacy trust contracts — taxi services, for example — has created better value, but those opportunities are diminishing. Some 60% to70% of current savings involve health provision and the jobs of those who struggle to provide care.

Some cuts are high profile and visible. They usually involve closures of care homes, mental-health facilities or dementia wards. The system says that there will be replacement facilities in the community and that there will be no job losses for individuals, but we know that major cuts to the capital care programme mean that there will be no replacement facilities. The closure dates required to facilitate the cuts cannot be achieved, and patients, clients and carers are left feeling

deep uncertainties.

Every Health Service post that is deleted reduces our capacity to deliver healthcare in the face of underfunding and equality. There are major ongoing cuts in the background. Home-care services that are run by the Health Service are now being substituted with private sector employees on substantially inferior terms and conditions. That damages local economies and care standards. Trusts are seeking productivity over the three-year CSR period, which is usually defined as delivering the same level of care with 10% to 15% fewer resources. That includes all categories of health workers and is driven by the requirement for an annual break-even rather than a rational case for cost improvement and service.

The slow and silent haemorrhage of care, therefore, continues week by week. Beds are closed, waiting times are increased, and operations are cancelled. The hard-won struggle in previous years to at least approximate European standards in health revenue and capital expenditure is now going into reverse.

The service remains underfunded in comparison with need. Its outcomes remain substantially unequal, its capacity for coping and making do has been stretched to breaking point, and the easy option, the non-pay element of savings, is not being achieved. Therefore, the policy option of exemption from the comprehensive spending review is the precautionary and clinically essential approach while the Executive consider strategic solutions to the consequences of decades of failure to prioritise health needs. That is the view of the health unions, which is shared by the Minister of Health, Social Services and Public Safety and by key people in the Health Service but was rejected by the majority of this Committee and the Assembly. We are calling on you to lead the charge on a rethink.

Ms McKeown:

I will begin by considering the context. The financial crisis in our Health Service is now clear and present to everyone, so the trusts are in contingency planning mode. In seeking to resolve the situation, what they propose is characterised by small-scale cost pressures and efficiencies, accounting moves that are not sustainable, an “Armageddon now” approach to bed closures, for example, and some toxic actions that are going on behind the scenes. Two of those are major reductions in the Marie Curie cancer care services, and there has been at least one proposal from one trust to purchase new domiciliary care provision with meals not included for elderly patients.

That is the state that we are in. That is happening against a background of a strategic analysis of the proposals not being conducted, either by the trusts or the wider system.

The impact of the situation on health outcomes and the associated costs of intervention and treatment are not being considered. The costs and social damage that are being created by well-documented health inequalities, and the blockage to addressing them, are creating the current situation. The impacts of financial pressures on the Department of Health, Social Services and Public Safety's targets and performance framework, including the accident and emergency targets and waiting times for elective surgery, are not being considered. If they are, they are not being published by those making the proposals.

The main response from the trusts is to prop up the system by meeting or fudging the cost pressures. That creates more cost pressures, because the trusts cannot realise what they say needs to be done. They have switched into survival mode. The system can achieve only what is being asked of it by running the service on a finance-led basis and ignoring health inequalities and outcomes. They find themselves in an impossible position.

There are some strategic solutions. A major underfunding of need is being demonstrated here, which is a legacy issue; it was not created by the Assembly, but it is not addressed in the Programme for Government. We have no evidence that it is being addressed in the discussions between the Executive and the Treasury, and the current trend in public finances makes its realisation very difficult.

We are backing the call from the Minister. We want Members to back the collective call from the Minister, the unions and the health professionals to re-prioritise the Budget and to do so in the current and future Executive funds. To date, there are little or no signals that the Executive have heard or acted on that call, either from within its ranks or from across the health system. I hope that you are going to tell me that that will change.

The only route to long-term financial and service health is to prioritise inequalities and prevention. There is immense growth in healthcare demand here. Specific action in those areas can contain cost pressures. The fewer people who need to use our hospitals, the more money we will save that will be available for prevention and community care. The inequality and prevention agenda must be reinforced.

A core framework would address social policies to improve equality and inclusion. It would address the leveraging of public expenditure to get a stronger health impact. It would give us better access to health and social care, particularly for those most in need. It is tragic that some of the proposals to meet the current financial situation are impacting on those who are most in need. It would mean adopting higher standards of care for the people of Northern Ireland, adopting genuine, environmentally sustainable solutions, providing assistance to support global health standards, addressing health inequalities and improving healthcare. It means thinking outside the box and looking at the bigger picture; that has been achieved in other places.

The building blocks that are essential to delivering that are an effective role for a cross-ministerial group on public health, which operates with openness and transparency; the reshaping of wider policies; and the leveraging of public expenditure. The Northern Ireland Executive need to engage and exert influence on Westminster, because the health of the people cannot be sacrificed in what happens to the block grant in the future.

We need to shift away from the assumption that commissioning is the only way, an assumption to which many people in the Health Service, including boards and trusts, are wedded. The only difference that commissioning makes is that it distances trusts from the core goals of raising health standards and reducing health inequalities. The commissioning system also blurs accountabilities and gives people a place to hide and say that they are not doing such and such — it is the commissioner. We also need additional monitoring of primary and secondary care, and in mental health, followed by action.

Therefore, the consequent changes, which should include learning from other health systems, will contain some actions that are obvious and some that will be controversial. All health trusts need investment for those changes. We must view the Health Service as a service that is delivered predominantly in local communities rather than in hospitals: 90% of healthcare is delivered in primary care, but we still focus the bulk of our attention on the remaining 10%. Our emphasis on hospitals does not provide the care that people are likely to need.

To meet those challenges, we need to galvanise the entire system and more fully integrate the Health Service, including the contribution of hospitals, GP teams, social care providers, patients and their carers. We need to develop new skills to support local services. Generalists, specialists,

nurses, allied health professionals and doctors must have all the right skills for patients.

We need to develop options for change with people and not for people. That is a current problem. We need to start from the patient experience and engage the public early to develop solutions rather than have them respond to predetermined plans that have been conceived by health professionals. All partners in the system need to put in place a systematic approach to caring for the most vulnerable people, especially older people, with a view to managing their long-term conditions at home and in the community, thereby reducing the chance of hospitalisation.

We need targeted action in deprived areas to reach out with anticipatory care to prevent ill health and to reduce health inequality. We need support for patients and their carers to manage their own healthcare needs and to help others with similar conditions. We need to empower multidisciplinary teams in community casualty departments to provide the vast majority of hospital-based unscheduled care. That could be networked, from telemedicine to consultant-led emergency units.

We need to shorten waiting times, inform patients by separating planned care from urgent cases and treat day surgery, rather than inpatient surgery, as the norm. That means that we need to enable better community-based access to diagnostics, develop referral management services and introduce a delivery function that will draw on best practice from across the world and further speed up patient access to services.

We need to concentrate on specialised or complex care, and concentrate those on fewer sites to secure clinical benefit and to manage clinical risk. We also need a step change in the development of regional planning to ensure that there are regionally based decisions on the shape of hospitals. We need to set a clear agenda for community health partnerships to work across barriers between primary and secondary care, and to engage with all the partners in social care to shift the balance of care.

In a climate such as this, in which the public and those who work in the Health Service fear and suspect all the change that is being proposed because most of it looks like radical cuts, and in a climate in which politicians feel obliged to defend the status quo in their own constituencies, it is impossible to have that kind of dialogue, which is what we now need. We stand on the brink of

the chance to create the kind of Health Service that we need in Northern Ireland, or to manage the disaster that is an underfunded system that is groaning under the weight of increasing cost pressures.

The first four proposals that I laid out have been adopted by the Scottish Government and are being implemented by NHSScotland. The rest of the proposals are drawn from models across the world, some of them in the US in particular. The US would die for our health system; its system is categorised by inefficiency. However, the extraordinary work that has been done by institutions such as the Joint Centre for Political and Economic Studies in the States, which has considered the economic burden of health inequalities, is producing the sums and solutions to put matters right.

For example, spectacular savings can be made if some attention is paid to the direct healthcare needs of African Americans, Hispanics and Asian communities — poor and vulnerable people. They are currently costing $230 billion over four years. Potential savings of $1·24 trillion in indirect costs could be made by addressing the needs of those population groups.

Our Health Service is not the same: its system of inequalities is different. However, the concept is similar, and we can bring it to our backyard, to people such as Lord Darzi and Richard Wilkinson who say that we have a moral responsibility to address health inequalities in our society but that doing so can achieve extraordinary health and well-being, financial and economic benefits.

That is what we propose to the Committee. We are saying that there is a chance to rethink, but that must be outside the box. Please seize the opportunity. We are very worried that the 60,000 people who work in the Health Service are not being heard and that we are not being heard. The Committee, its Department and its Minister are not being heard in the way that they must be and, today, we propose that they should be.

The Chairperson:

Thank you for keeping to time. As expected, many members have questions. I will get the ball rolling by playing devil's advocate. Is it not strange that all the cuts that we have seen in the past few weeks appear to have been targeted on the most high-profile element of services? We are not hearing of administration blocks being closed down or public relations offices being savagely cut.

I ask because I trawled through recent job advertisements in the newspapers and found the following: an assistant director of performance management with a salary of £44,000; a risk manager, £29,000; an information analyst, £25,000; a senior employee relationships adviser, £25,000; and a HR and equality officer, £25,000. An organisation that continues to recruit people at that top level as hard as that does not strike me as one that is in crisis. Do the witnesses have any evidence that the cuts are deliberately targeted on high-profile services?

Ms McKeown:

I want my colleague Kevin McAdam to reply on behalf of the negotiating unions, but I make the point that members will find in the Hansard report evidence that we have already given to the Committee.

We think that we have a dysfunctional health system, half of which was reorganised by direct rule and inherited: the super-trusts. The other half was introduced by the current Administration. Time was taken to do that, which is fair enough, but it remains a dysfunctional system because of the way in which it was created. It is not the ideal model that we all bought into. Half of it was imposed on us; therefore, it is not the most effective system.

We cannot change that; doing so requires a collective, political decision. The review of public administration has failed us. It is wrecking us in the Health Service. I hope that lessons have been learned by the education sector when it moves on 1 January 2010, and I dearly hope that lessons will be learned by local government when it moves some time later. However, the review of public administration is failing the Health Service.

Health was pushed in a hurry, and, consequently, we do not have ideal systems. Of course we believe that there are areas in which things could be done better and more effectively. There is nobody among the 60,000 people who work in the health system better placed than us to have a view on that, which is why I would like Kevin McAdam to speak on their behalf.

Mr Kevin McAdam (Unite):

To answer the Chairperson's question directly, it must be understood that the review of public administration took away all the administrative functions and reduced the unnecessary administrative functions in the system to the position where all advertised jobs are not only

essential but have been screened to ensure that that is the case. No one takes the job of filling those vacancies lightly.

The review of public administration has impacted on the service; I will speak on behalf of the trade unions to provide a flavour of what is happening on the ground. As a result of the review of public administration, we have had to manage cuts, and the service has been stretched. Moreover, the CSR has had a further impact. We are approaching the stage at which there is nothing left to cut. To date, vital acute and community services have been shaved, and cuts are becoming unsustainable. As a result of the review of public administration, we are carrying high levels of vacancies in comparison with the old system. For example, the level of vacancies in pharmacy in the Belfast Trust is 15%. Despite the fact that pharmacists have been one of the good stories in the Health Service in recent years, the trust has been asked to increase the number of vacancies in the system. Through their use of generic drugs, pharmacists have saved millions of pounds in the past number of years.

All that information is necessary to understand that the review of public administration has already had an impact. We now face further cuts. Trusts make evocative arguments to the effect that their administration functions have been reduced. They now consider that the only way to make cuts — and I do not agree with them — is to close wards and reduce services. Indeed, one of the worst aspects is that community services have been targeted because they are not high profile.

We are conscious of recent discussions and outcomes of cases in Birmingham, and also the Baby P case, in which children were at risk. Northern Ireland is heading quickly to that type of environment. No community services are left to cope. In summary, we are moving backwards rather than developing a service that can deliver and grow. It needs investment to grow, and I understand that half of Northern Ireland's Budget will be required. However, we are appealing today for the little bit more that the system needs to provide the service for your constituents and our members.

The Chairperson:

The press comments and the information supplied by your offices indicate that the trusts must achieve total savings of about £70 million. We know that the Belfast Trust must achieve £25 million and that the Western Trust must achieve £9 million. Seventy million pounds equates to

1·6% of the entire health and social care budget. Some would say that an organisation of that size could find efficiency savings of 1·6% to avoid cuts to A&E, maternity services, and so on.

Ms McKeown:

Therein lies the fundamental problem. We have reorganised the Health Service with an inherent deficit. From all the work that has been completed, we recognise that key areas are experiencing major underfunding. Lily has outlined those areas, and the big ones are mental-health services and services for children. Moreover, a 17% funding increase is needed in acute care. It is possible to find savings in any budget but not savings of that proportion.

The Executive considered Treasury requirements and divided 3% efficiency savings equally across all Departments. That did not result in an equal outcome. Health has the biggest budget; however, therein lie the biggest problems and the biggest health inequalities. That 3% efficiency saving requirement is forcing the Department of Health, Social Services and Public Safety to create a further impact on areas that already suffer from unmet need and underfunding. That problem needs to be addressed now. The approach is not equal and does not promote equality; it compounds health inequalities, and people should step back and consider the real picture.

If it was true the last time that we had a devolved government that the population's state of health left much to be desired and that health inequalities were some of the worst in western Europe, if it is true, on the evidence given to this Committee and to this Administration by the Chief Medical Officer that we have not moved on that, it is true that we need to invest in healthcare at those levels and in those places. If we do not do that, more people will go through the doors of our A&E departments and into inpatient facilities in our Health Service. It is a spiral that will continue until we call a halt to it, do something about those inequalities and address what is happening to people now. That needs investment.

Dr Deeny:

I have a quick "yes or no" question: have you seen the proposals that have been put forward by the five trusts?

Ms McKeown:

We have seen the first round of proposals that were approved by the Health and Social Care Board a couple of weeks ago. We heard them by sitting in on public board meetings, and some of

the chief executives have given us direct briefings. There is a new set of contingency proposals, but there has been an inconsistency in briefing workers and unions alike at trust level. However, we do not have a further set of costed proposals in our hands.

We have listened to what the trust boards have said about the size of the problem. The last time that we looked, the deficit in the Western Trust was approximately £9 million, but the current prediction from that trust is that, if it does not take the actions that it is proposing, it will be over £25 million in two and a half years' time.

Dr Deeny:

Have you seen what the Western Trust is proposing?

Ms McKeown:

We have heard about it.

Mrs Kerr:

That is the point that we need to make. Like you, we have seen the first set of comprehensive spending review proposals. There is a new set of contingency proposals that the trade unions are not in receipt of, but we are receiving leaked material from managers at local levels, and we have been speaking to staff members. We do not have the full picture either.

Dr Deeny:

I could not agree more with what has been said. We were supposed to have had modern health centres that would encourage health promotion and disease prevention, but they have been put on the back burner. I am concerned about front-line services across Northern Ireland, because those proposals will have an effect. I hope that that will not be the case.

Of course we could do with more money. However, I take issue somewhat with Kevin McAdam. I declare an interest as a GP; I have talked to many of my GP colleagues about the issues. I agree with Kevin about underfunding; I think it was Patricia who used the phrase "underfunding of need". That is the issue. However, we must examine how the money that is coming in is spent. There are fewer than 290,000 people in my local trust area. Across the water, that size of population would be served by one hospital and by one authority.

Can you honestly say that our system represents efficiency? There are eight directors in my local trust, each of whom has an assistant director. There is a director of finance and three assistant finance directors, as well as two other heads of services, all in the one trust. There is a director of nursing and three assistant directors of nursing, one of whom is involved in professional development and performance, and another is responsible for research and development.

As a health professional, I wonder why we cannot get the money that we need for primary care. Someone said earlier that the review of public administration has failed us. It has also failed us in that health professionals are saying that they were led to believe that administration would be scaled down, leaving us with good managers and good administration, or at least just enough to do us. Yet we seem to have overlap, and it has been said to me that there is even more bureaucracy now.

The Chairperson:

Dr Deeny, are you coming to a question?

Dr Deeny:

That is my question: do you not think that we could be more efficient by cutting those sorts of jobs, rather than cutting A&E units, elderly care, children's services and primary care?

Ms McKeown:

I repeat my point. We opposed the creation of five super-trusts. We did not want any trusts at all. We wanted to go the route of Scotland. The Hain Administration landed this on us and put it in place, put through the legislation and had it de facto by the time of devolution. There is a real problem there. We are not happy with it, and we are not happy with the purchaser/provider split, which also creates a false economy. That could and should be changed.

All those years ago, Maurice Hayes did not stray into what the administration of the Health Service should look like when he produced his review, but he did have sound ideas about the five kinds of health circles that we should have. In the past, we had a system of four boards where one would have done. We have one now. However, we then had a system of units of management with collective responsibility across the Health Service for health planning and delivery. We were promised that we would return to that kind of system, and everyone signed up

to it. However, somewhere along the line, the Hain Administration changed that plan. Having wrecked the English Health Service, they thought that they would wreck ours, and they put those super-trusts into place. Therefore, the monster has been created, and we are stuck with it until we change it again.

We do not say that it is your fault: we say that that is one of the things that makes it dysfunctional. It does not have to be five independent super-trusts: there must be a holistic Health Service, which will need to be managed. We are in a crazy situation in which five super-trusts have been created, but no one runs Belfast City Hospital, the Erne Hospital, Altnagelvin Area Hospital or the Royal Victoria Hospital. They have all gone and accountability in the service has gone askew.

Who on earth could keep track of what is going on? There is only a horizontal structure, which is appropriate for medical delivery but not appropriate to deliver at the level of the institution and all that goes on inside it. That was created before devolution, but it is what we have, and we need to start thinking about how to change it.

Mrs McGill:

May I ask for clarification of one point?

The Chairperson:

There are 100 years of experience in various parliamentary forums around this table. Members all know that one should always ask a question; one never makes a statement. If you want to make a statement, use a phrase such as "Is it not the case that … ?" or "Would you agree with me that … ?" However, please do not make a statement for the benefit of the 'Strabane Weekly News' or the 'Banbridge Chronicle' or whatever. Please try to ask a question.

Mrs McGill:

I just wanted to be clear about that. Kieran has made a number of questions.

The Chairperson:

Yes; he got away with it, but he should not have done so.

Mrs McGill:

I do not mean it that way. Kieran represents the west, as do I.

I thank the witnesses for their papers. It would have helped me to receive them before the meeting, but I have them now. Lily said that we need to prioritise and to ask collectively for the Health Service to be exempted from the comprehensive spending review. Patricia said that we need targeted action in deprived areas. I wonder whether those aims can be reconciled. Is one within the other? What is the situation?

Furthermore, Patricia referred to crisis, and she spoke of fear and suspicion. Several people have contacted me about that. However, I am concerned that we do not generate further hysteria and crises from this meeting and whatever happens after it. We must be careful about the needs of patients in hospital and the staff who work for them. We all have a contribution to make, no matter which organisation we are in. We have to work collectively to get a result. I am sure that improvements can be made.

I will return to the question asked at the beginning about exemption and targeting. In the west, there were many difficulties about the removal of acute services from Tyrone County Hospital. People have now contacted me about the removal of radiology services. Urgent care and treatment cannot be sustained if radiology services are not available at night. Thank you, Chairperson, for your indulgence.

Mrs Kerr:

I believe that my statement and Patricia's statement go hand in glove, for want of a better expression. We are calling for health to be prioritised because we remember that, during the election, health was the number one priority on the doorsteps. I do not think that anyone will disagree with that. There is an unmet need, and Patricia has outlined the fact that it was inherited in many ways. When there is an economic downturn, people need their Health Service more than they ever did. Those issues are easily reconciled.

Ms McKeown:

I also want to stress that, collectively, millions of pounds have already been found in efficiency savings in the Health Service over the past year. Extraordinary efforts were made to find millions of pounds. The Belfast Trust started life with an inherited £40 million deficit, which was not of

its own making. It made inroads into that, and hoped that it would make inroads amounting to many more millions of pounds, but then it got into the business of having to make efficiencies in front-line services.

Efficiencies have been made and more can probably be secured, but everyone must agree on what should not be touched, what needs some investment, and where the real problems lie. If we put some money into those issues today, in another five, 10 or even 20 years' time, we may have saved £1 billion, £2 billion or £3 billion. It is the only approach, but we in the system seem to be incapable of taking that step back and saying that, collectively, we are prepared to roll our sleeves up.

The 60,000 people who work in the Health Service have come up with all sorts of ideas already and have saved money. They see crazy things happening every day of the week, and they see smarter ways of doing things. They need to know that they are being listened to.

Mrs McGill:

You mentioned the Belfast Trust and its legacy. Sperrin Lakeland Health and Social Care Trust had a deficit of £3 million, and the Western Trust had to clear that as well as dealing with efficiency savings. That is a problem, particularly in the west.

Ms McKeown:

Every area has inherent problems. Some cost more than others.

Mr Gardiner:

I thank Lily and Patricia for their brilliant presentations, and I am pleased to note that the Minister of Health, Social Services and Public Safety replied to you, although I am disappointed that other Ministers did not. Before the summer recess, I was also concerned about the budgeting, and I asked whether the Minister of Finance and Personnel would make funds available, particularly given the possibility of an outbreak of swine flu. I am still waiting for a reply; I have not received it.

As Lily mentioned, underfunding is the problem. We must all examine that issue collectively. During the presentations, I was thinking that MLAs are getting a bad press at the moment because of our expenses, and so forth. However, we could all join together and be prepared to go without

a salary for one, two or three months and pour that money into the Health Service. I would be quite prepared to do that, but we would all have to do it, and the unions might also have to help out if we are in a crisis.

The Chairperson:

Is there any reaction to that suggestion?

Ms McKeown:

If you had radical proposals, we might be able to match them.

Ms S Ramsey:

There is a surplus in the Department for Employment and Learning budget; perhaps you could ask your party leader for that.

Mrs Kerr:

I will reinforce the point that we want to be part of the change. We want to ensure that there is a well-run, world-class Health Service. We are just as dedicated to getting rid of inefficiencies as you are.

Mr Gardiner:

We join you on that.

Mrs Kerr:

I do not think that we are at cross purposes. We all want the same thing, and we all have to push together to get it. None of us should lose sight of the fact that health is the only service to date that has had to go through the RPA and all the traumas and savings that that necessitated. The long-standing deficit and the CSR have put the clampers on it. I agree that we do not want to panic the public, but we need to be honest with one another and state what the problems are.

Mr McCallister:

"Is it not the case that … ?" *[Laughter.]* I will be very brief because I am aware that every member wants to ask a question.

Your presentations have been very interesting. Patricia makes a strong case for the Public

Health Agency. It was interesting to hear comparisons with the US system. The Americans would probably die for our system. We must remember that. The members of the Health Service whom you represent carry out a great deal of good work. We should not lose sight of that. Many patients are very grateful for that.

We supported the attempt to exempt the Health Service from delivering 3% efficiency savings. I am interested in your comments about providing healthcare on fewer sites, which is a controversial proposal.

Ms McKeown:

I said that some of our proposals were controversial, but they must be taken as a whole. You have to listen to the range of points that we make. We are not pump-priming the primary, preventative and community care ends, which is where some of the greatest health inequalities are. If we do not pay attention, the wards will fill up. Somewhere along the line, the people of Northern Ireland have to say that we cannot go on like this. The system could not sustain that in the long term. It will run out of money. We have a chance to do something different. If we do that and have an honest and democratic conversation with the people — that is all of you and all of us — people will think in a different way.

To give an example: I can recall when there was much angst about the fact that, if someone cut off their little toe while gardening, he or she would be transferred to the Ulster Hospital rather than the City, Royal or Mater hospitals. That person, as a citizen of Belfast, would be a bit put out that he or she did not get to his or her local hospital, until word got out that the people who were the best at sewing your toe back on were in the Ulster Hospital, so that is where that person needed to go.

Our Health Service has an extraordinary range of specialties. It is a world leader in some of them, but we do not do it that way. People are sent to accident and emergency departments depending on whether it is Monday, Tuesday or Wednesday, not depending on whether they are having a stroke or that they are the walking wounded. That situation has not yet been worked out and it must be. To propose radical change like that in the current climate will lead people to think that a local accident and emergency department is about to be closed down. It is not about that; it is about change.

I attended a Northern Trust board meeting a couple of weeks ago to view the plans that were being unveiled for the new health centre in Ballymena. A representative from the Patient and Client Council was present, and she was very upset — as we were — because the plans did not include the promised minor surgeries unit. That was a good example of how to combine many primary and preventative health measures, and a promise had been made that a minor surgeries unit would be included in the new health centre to prevent people clogging up Antrim Area Hospital or having to come to a Belfast hospital. That unit is no longer included in the plans. When the board was asked why, it said that the commissioner had taken that decision. The trust was hiding behind changes in which people had been led to believe that that was what they were going to get.

For example, if I have been waiting in an A&E department for seven hours and am getting very irritated with the system and the staff, and somebody tells me that I am waiting because casualties from two road traffic accidents have come in there is also a stroke patient, I will calm down because I understand why I am waiting. I probably would not have to wait if A&E were organised differently. For example, if I am waiting for an X-ray, I should not be clogging up an A&E department. However, that is what is happening. If people are part of the conversation and if we talk to GPs and staff, we can find better ways of doing things. We do not seem to be capable of considering situations in different ways.

The Chairperson:

I am going to let Mrs Robinson come in as she has indicated that she has to leave at 3.40 pm. Alex has kindly given up his slot.

Mrs I Robinson:

I want to bring some reality to the discussion. Although I welcome listening to what you have said, I am, to say the least, bitterly disappointed. I thought that I was going to hear an unbiased presentation. Sadly, I think that the unions appear to be doing the Minister's cheerleading for him by blaming everybody but the Minister. In common with every other Minister in the Assembly, the Minister of Health, Social Services and Public Safety made his bid and got the money. However, unlike all the other Departments, the Minister of Health, Social Services and Public Safety was able to keep any efficiency savings made. No other Department was able to do that. I am very sceptical. You have been to see the Minister, and he has pointed the finger and said that everybody else is to blame and that it is not an inadequacy on his part to do the job.

Scotland has a Parliament, and, therefore, it has tax-raising powers. Northern Ireland and Wales have Assemblies, and, therefore, do not have tax-raising powers. It is unfair to compare Scotland with Northern Ireland.

I had hoped that you were going to tell me why the Minister is not keeping his promise not to touch front-line services. That is on record: the Minister made that promise in public view on the Floor of the House, and we were led to believe that that was the case. I am very sceptical as to why, all of a sudden, we are hearing about maternity services and women being sent home six hours after having a baby. That is an absolute scandal. We are hearing about 170 bed closures in the Belfast Trust and about cuts in the Ambulance Service. Why are we seeing cuts in all the front-line services? I can tell you why: it is to get people such as you on board to start shouting and doing the work for the Minister. I am very sorry to have to say that. I thought that you would come here fighting for the rights of your members, not to tell us that we are doing the job wrong.

Ms McKeown:

I have been a union official in the National Health Service for the past 30 years. I have lived through a range of reorganisations. I come from an organisation that has very strong views on how a good Health Service could be constructed. It is an unfortunate word, but, if we are "cheerleading" for anything, we are cheerleading for the National Health Service.

Mrs Kerr:

We make no apologies for doing so.

Ms McKeown:

If politicians come onside, that is great. Make no mistake: as far as we are concerned — and the reason why we are giving evidence to the Committee today — we believe that politicians should be at the service of the people, not the other way round. Let me make it absolutely clear: we are nobody's pawn, and we never will be.

With 30 years' experience of what is happening to the Health Service, with the benefit of the excellent research that has been conducted on the position of the people of Northern Ireland, the state of their health and the state of poverty, with very clear equality tools, and with the

possibility of creating something new and decent, we have come here today to tell the Committee that there is a chance of doing that. However, if you fall back into protecting the current status quo in your own constituencies, playing party political games, or not acting collectively, you do a terrible disservice not only to the entire population of Northern Ireland but to the people whom you already know are suffering from the worse health inequalities, in some cases, in Europe. You are doing a terrible disservice.

I would like you all not to knock spots off one another or make political points; I would like you to work collectively. However, do not ever accuse the trade union movement of taking sides in that political fight. We are here to represent the people who work in the Health Service, the people who benefit from the Health Service, and the Health Service itself, which we fought long and hard to have created.

The Chairperson:

I would like to let Mrs Robinson back into the discussion, but I know that Lily is very keen to speak.

Mrs Kerr:

Thank you, Chairperson. I have to say that I am bitterly disappointed that we came here today to seek your assistance in defending the Health Service. Like Patricia, I have a strong track record of saying and calling the issue as it is. We are nobody's cheerleaders, but what we will do is support a Minister, any Minister, who stands up for the service that he is there to provide.

I am disappointed that you have accused us of bias. If we are biased about anything, it is about the passion that we feel for the National Health Service, and I think that we have the support of the Northern Ireland community in feeling that and saying that.

Mrs I Robinson:

I do not take lecturing. I know what my role in life is, and I do not think that anyone here could say that I have not worked hard for the health of the community. Therefore, I will not be questioned on my input as an elected representative. However, you have come here today singing the same song as the Minister —

Mrs Kerr:

We do not apologise for that, Iris.

Mrs I Robinson:

I find that quite unbelievable, because the Minister made a promise. I say to you: target the Minister and his not keeping his promises.

Mrs Kerr:

I say back to you that we are targeting where we believe the fault lies and a system that is not providing enough money.

Mrs I Robinson:

Where do you think that the money comes from? We get a block grant from Westminster. The Minister gets 48% of that total: £4 billion. Where do we get this money that is needed?

Mrs Kerr:

With the greatest respect —

Mrs I Robinson:

Do we take it from all the other Departments?

Mrs Kerr:

With the greatest respect, my submission indicated where we felt that money may well be saved.

Mrs I Robinson:

I would have liked to have heard from you today about all the top-heavy management in hospitals. It should not be the ordinary worker who is targeted; it should not be the front-line workers. We are all in agreement about that. However, why are you not asking the Minister why he broke his promise?

Ms McKeown:

We have given the Committee a sophisticated view of how to reconstruct our Health Service and deliver to the people. That view is supported by the world's leading experts on healthcare delivery, particularly in circumstances such as our own in which such a substantial part of the

population has such unmet need. We gave you that sophisticated view, and also asked you to think big on this one; it is do-able. However, if you do not think big, we will reach that place where continual usage and need to be hospitalised will break the back of the system.

Mr McAdam:

I do not have the physique of a cheerleader, and I do not claim to be a cheerleader for anyone. Nor will I be accused of being biased or supporting any political party. I came here today to impress on the Committee — whose role, as I understand it, is to hold the Minister accountable — the need for something to be done to a Health Service that is creaking, whether through underfunding or poor management. Nor am I here to support a management case and to say that everything that management does is excellent. Far from it: that also needs to be changed.

However, the Health Service is fundamentally underfunded in the face of a growing need in Northern Ireland. That need is not being met, and it needs to be considered again. We need to ensure that growth is allowed. We are strangling the Health Service and setting it back 30 years, and that is happening on the Committee's watch. We are going to go back to offering only those services that can be provided. Health provision is now like a balloon debate. It is the unit or section of the Health Service that can argue the loudest for their cause in a trust that receives the money to do the work. That is no way to deliver the Health Service in Northern Ireland.

The Chairperson:

If the recent tests that were done by the University of Ulster are anything to go by, the only person in this room who has the physique of a cheerleader is Carmel Hanna. She came out tops by miles for her fitness and health.

Mrs D Kelly:

The SDLP did not vote for the Budget or the Programme for Government. You know about the issue of ministerial responsibility and the code of conduct, so you know the story about why the SDLP's Minister had to vote one way while the rest of the party voted another way on the Floor of the House. I am sure that you will agree that there are several contributory factors in tackling health inequalities and poverty, of which health is one.

Lily, the gist of your presentation was that the priorities in the Budget and the Programme for Government should be shifted to make health exempt from efficiency savings. Your presentation

made no other suggestions about how things might be done better.

Patricia, you referred to a number of reports. I would be grateful if you could forward the report about the situation in the United States to the Committee.

As someone who worked in the Health Service for 22 years, I am familiar with the changes that took place over many years. In 1988, the Griffiths report was produced, which favoured people being supported in the community. As we all know, the money that has been saved from hospital closures has not followed across the community. Over the past 30 years of change, there must have been opportunities for conversations on the suggestions that you are promoting as a new way of thinking about the delivery of health and social care. Did those conversations take place, and was the trade union movement listened to?

The Chairperson, playing devil's advocate, listed a number of jobs that are currently advertised. Unfortunately, we live in a litigious society, which is partly why those posts had to be advertised. In the view of the trade union movement, even with five trusts, were there opportunities for back-room services to be further rationalised and shared across the trusts so that cuts could be made? PR departments and finance departments are only two examples of that.

I declare an interest as a former allied health professional. If patients are to be kept at home, allied health professionals and social-care workers have a key role to play. The little information that we have received from trusts has not included anything on what efficiency savings are to be made in those areas. From a trade union perspective, what evidence do you have that services are going to the community, or are waiting lists getting longer across services?

I understand that many nurses who qualified this year, and perhaps last year, are still waiting for a permanent job. I understand that the Health Service is still very reliant on agency workers. Have any of you investigated the costs of that and where potential savings could be made by filling permanent posts?

Mrs Kerr:

We have been highlighting all those issues. Patricia and I talked about the number of vacant jobs in the Health Service and about the use of agency and other casual employees.

Mrs D Kelly:

It would be much better if that were a costed analysis, if that were possible. You may have more information on the specific number of jobs, rather than making a general statement.

Mrs Kerr:

If we had gone into every specific detail, we would not have been able to keep to the Chairperson's directive to keep the presentation to around five minutes. I take your point.

Mrs D Kelly:

I thought that we were going to hear such detail. Perhaps you can send the information to us, and we can raise questions on it.

Ms McKeown:

We did not come here to propose cuts: we came here to oppose them.

Mrs D Kelly:

I was not suggesting that there should be cuts; I was suggesting a better use of money.

Ms McKeown:

The relevant information is in the public domain. For example, the trusts have produced documents on financial information in their response to the first round of CSR. The Belfast Trust produced a finance document for its last public meeting that showed that some £23 million was spent on agency workers. That figure is for medical, nursing, admin and support services, and it was spent because the trust was holding vacancies — I do not have the figures for the other trusts, but they are all holding vacancies. The Northern Trust has also produced figures, but it is trying to decrease its use of agency staff and fill the vacancies, and it is being criticised for doing that.

People throughout the system are in a fairly impossible position. We are witnessing a casualisation of very important jobs in the Health Service that have never been casualised before, which is a frightening situation. All that needs to be put right. Much of that is a consequence of the review of public administration and the decision across the trusts that the vacancies had to be held. Despite being told not to, the trusts continued to hold front-line vacancies because they inherited deficits and knew that they had to find money from somewhere. That is terrible and should not have happened, but I understand why they did it. However, the trusts have to stop.

That sort of information is in the public domain.

For 30 years, we have put on record our views on the type of Health Service that we should have. We have engaged with every Government, put our ideas down in black and white, fed into every review, produced the evidence base and taken the time to examine comparative systems and see how things can be done in a different way, which is what we are asking the Committee to do.

Mrs D Kelly:

Do the two Kevins have anything to say? I asked some specific questions.

The Chairperson:

Mr McCabe, you have got away quite easily.

Mr Kevin McCabe (Northern Ireland Public Service Alliance):

My colleagues have made the salient points, but I will make a number of comments. It was interesting that the first line of questioning from the Committee was on salaries, which implies that the Health Service is not that bad and that, if the Health Service can afford to pay salaries in the ranges that were cited, we are crying wolf.

The cutting of management posts is one thing, and it is very important. I am no defender of high salaries, and I am not defending positions such as director or assistant director, but the number of legacy trusts has gone down from 19 to five. With regard to the scenario that Kieran Deeny painted, you will hear people saying that the span of responsibility and the geographical spread of the trusts are putting much more pressure on fewer resources, which is a problem.

People in the Health Service tell me that the units of management system, which were in the pre-trust era, were much more effective and efficient. In Belfast, for example, the Royal, City, Mater and Musgrave Park hospitals were all under one unit of management. However, Mrs Thatcher came along and said that there should be acute and community trusts. Those trusts all created directors of finance, personnel and human resources, and we had to undo all that. That is just one aspect.

Patricia said that we have to get the right model. The focus of our discussion is wrong; the

issue is the inherent underfunding of the Health Service. One Committee member said that underfunding was the Minister's fault. We could discuss the Barnett review and the allocation of funding to Northern Ireland and whether we are getting as much funding as we should per capita. We are clearly not receiving what we should be; any money that is invested in the Health Service is allowing it only to stand still. Unfortunately, the focus of today's discussion has moved away from what we came here to discuss: the level of cuts that each trust faces. The savings are not just about staffing or front-line services; they come in many dynamic shapes and sizes.

There are savings of £13·8 million over three years for the RPA. There are regional savings, productivity savings and service redesign savings. There are programmes about which I am particularly concerned such as those for elderly people and the community, mental health and learning disability and, not least, children's services.

Kevin McAdam flagged up the particularly dire situation that we face with the protection of children, which is close to the point at which we will have a replication of the Baby P incident in England. Indeed, last week, a report on children's services in Birmingham stated that they were not fit for purpose. We need to get back to the agenda. I have discussed how only one trust seeks to save money. That is replicated in the other four trusts.

Mr Easton:

Thank you for your presentation. We know that two of the second set of proposals from the trusts have been agreed by the Minister, yet the Committee has not seen those proposals. We have not been informed about them. We did not know about any of those proposals, which have come at us all of a sudden.

Do you agree that the fact that we were not told that information represents bad management by the board and the Department? You were taken by surprise. The Committee has also been taken by surprise. Although we saw the initial efficiencies, much of what has come out in the news since was not included. The Committee was kept in the dark. Do you agree that the Minister and the Department should have let the Committee know what was coming?

Mr McAdam:

I want to respond to that first, if I may. We are used to being squeezed from either side by UNISON. However, we cope. *[Laughter.]*

The second stage of savings, to which you referred, amounts to the trusts' failure to implement the first CSR commitments that they made to the Minister. The current situation is that they cannot meet those commitments, and there is a further shortfall. All that that demonstrates is that, initially, the CSR was wrong, and it was not possible to achieve it. I do not come here with an answer: I come here to pose a question. A crisis now exists. Something needs to be done.

The goodwill that abounds in the Health Service is draining away fast. That will hasten if staff are sought to work unpaid overtime — any more than they have worked already. Nurses have already provided all that and more. In one or two months' time, when we must implement pandemic flu proposals, nobody will be fit — never mind willing — to deliver them.

Mrs Kerr:

On your point about the second set of proposals, Alex, herein lies the problem, which I believe that I referred to when I answered Kieran's question earlier: we have not seen the second set of proposals. The Department has not seen them, nor has the Minister. Our understanding is that they are contingency plans that have been drawn up by the trusts.

Mr Easton:

The Minister agreed to two of those proposals: those that relate to the Northern Trust and the Ambulance Service Trust.

Mrs Kerr:

You are talking about the original comprehensive spending review. Those were amended proposals that, to our understanding, went through the Committee and, indeed, the Assembly.

Ms McKeown:

I want to make a recommendation on that matter, because one issue is that the rest of the jigsaw pieces in the top-tier structure have come together only within the past few months. We have the Health and Social Care Board; the Public Health Agency; the Business Services Organisation; and the Patient and Client Council. As I understand it, local commissioning groups will be in place by November. The five trusts have been around for the past two and a half years. Therefore, the system has not really functioned that way until now.

The Department tells the trusts the amount of money for which they are accountable. The trusts make proposals. The proposals go to the Health and Social Care Board because it is responsible for how much healthcare is delivered on everyone's behalf. It must make decisions and recommendations, which it sends to the Minister. That, in turn, creates another set of decisions that need to be made. I would not be prepared to pronounce how that should be done. Certainly, as the scrutiny Committee, you want to know what proposals are making their way through the system, and how they are making their way. We also want to know. Ultimately, those proposals affect the people whom we represent.

That is the current situation. My understanding of the first set of proposals is that some have gone through and some have not. Issues such as the closure of the Whiteabbey Hospital and the Mid-Ulster Hospital are included in the first set of the proposals but have been delayed because of a clinical-need crisis. The second set of proposals is probably with the permanent secretary of the Department, because of the accounting officer relationship between him and the trusts' chief executives. However, those proposals will also have to be signed off by the Health and Social Care Board.

Mr Easton:

The witnesses have discussed the need for the Department to be exempt from efficiency savings, despite the fact that money already flows back into it, which is not the case with other Departments.

If the Department were exempt from the 3% efficiency savings, cuts would have to be made in other Departments to take up the slack. What cuts would the witnesses like in those Departments? For example, which schools would they want to close?

Ms McKeown:

We have discussed a holistic model, and the type of healthcare system that we need does not solely concern the Department of Health, Social Services and Public Safety. Education, the provision of public housing and the development of an anti-poverty strategy all have a role to play. Indeed, every Department has some part to play in addressing health inequalities, and those Departments must all put something into that.

The Executive took the original decision to front-load the economic strategy, and, in doing so,

they de-prioritised the health budget. We are calling for the re-prioritisation of that budget. We are aware that everyone has real difficulties in confronting budgetary issues, not least our Government, which have to make decisions about how the financial pie will be divided. However, as long as the overall Budget is considered as 12 or 13 separate budgets, we will continue to be in this mess. Instead, we must start to think about the Budget as a set of budgets in which all Departments can make a contribution to tackling health inequalities and poverty, which is an underlying cause of those inequalities.

If a proper impact assessment of the original Budget and Programme for Government had been carried out, that need would have been spotted. However, taking money out of the healthcare system and putting it into areas such as Invest NI without attaching conditions to address economic inequalities is wrong; jobs make people healthy, and good jobs make them even healthier. If that assessment had been carried out at the start of the process, what has happened to date could have been averted.

Mrs D Kelly:

That would not have helped Invest NI, mind you.

Ms McKeown:

It might have done, but, as it was not there originally, we must take a different view.

The Chairperson:

Ladies and gentlemen, we have only an hour and a half left of today's meeting. We have been going a long time, and I would like to get home before Christmas. Can we try to move on, because the Committee still must hear evidence from the Ambulance Service?

Mrs Hanna:

The Committee is at a bit of a disadvantage. It did not receive the witnesses' presentation until this afternoon, and, although Committee members have been restricted to asking brief questions because of time constraints, the witnesses have given rather long conversational answers. I have no problem with that except that a conversation is not taking place between both parties, and I have not had the opportunity to give my views on anything. From what I can remember from the witnesses' presentations, I agree with most of their points. We certainly require more debate and discussion, but urgent decisions must also be made.

I worked in the Health Service for most of my adult life, and I have also worked in other parts of Europe and in developing countries. That work has given me the opportunity to compare and contrast the model of healthcare provided here with the provision in other countries. However, we are where we are, and some decisions must be made.

I also agree with the witnesses' remarks about inequalities in our society. I worked as midwife on the Shankill and Falls roads for many years, and I was able to see where early intervention was required and where the problems lay. Furthermore, the challenges in the public's lifestyles are reducing life expectancy and are connected with inequalities.

We must make suggestions to the Public Health Agency about what can be done. Do the witnesses believe that, if we focus on healthcare, considerable savings could be made and that that could help people to stay healthier? I am trying to think of practical things that we could do now. We have to think in the long term and in new ways. What should we do now?

We spent billions of pounds on Peace and on targeting social need, but I have yet to see any difference in outcomes. How do we remedy that situation? We need to think quickly about changes that we want to make. I am frustrated because we cannot see change, we do not seem to be getting the message through, and we are not doing anything to remedy the situation.

Lily, I am not sure whether you mentioned the parties that supported the Department's exemption. I never bring politics in here, but that remark was certainly political. I do not know whether you now agree with the SDLP, which did not support the Budget because it did not ring-fence front-line services. The whole point of devolution is that we have local knowledge, so we have to —

Mr Easton:

Are you going to ask a question?

Mrs Hanna:

I need an opportunity to say something.

The Chairperson:

Perhaps you could couch that in the form of a question?

Mrs Hanna:

I did ask whether she agreed that the SDLP was right to vote against the Budget. *[Laughter.]* The SDLP asked for front-line services to be ring-fenced, but it did not agree to exempt the Health Service from making savings, because all Departments must make them. However, savings should be strategic, and local knowledge should be used to identify where they should be made.

Mrs Kerr:

May I give a quick answer? I agree that the SDLP was right to vote against the Programme for Government —

Mrs Hanna:

I am glad to hear it.

Mrs Kerr:

— but wrong to vote against the Health Service being exempt from the comprehensive spending review. I believe that the parties that failed to support the exemption were wrong, but that does not make me party political; it makes me someone who states the facts.

The Chairperson:

May we have a second question from Mrs Hanna?

Mrs Hanna:

I did not say that you are party political, but you did bring politics in, and that was all that I said. Do you really believe that we are going to get a bigger health budget? When one considers that 5% to 10% of the UK economy has been knocked out permanently and the fact that we have a block grant, no tax-raising powers and not enough wealth here to raise taxes, do you really think that we will get more money?

Ms McKeown:

We might not, but if we were all to fight for it together, there would be a real chance. Most of the proposed solutions that we have suggested to the Committee have been presented in shorthand form. Major work has been carried out in this area. For example, I would point you towards Professor Richard Wilkinson's work.

Mrs Hanna:

I have met him umpteen times.

Ms McKeown:

He has spent 30 years working on this matter, and he now has clear evidence that starting to deal with health inequalities would turn the system around and make it better for everybody. People's quality of life and economic prospects would also improve. That is hard, factually based evidence from research that has been undertaken. We are happy to provide the references, although several of you are already familiar with them. Nevertheless, the evidence is there and the work has been done, so we do not have to reinvent the wheel. However, we must be serious about the matter.

Ms S Ramsey:

Members are getting ready to leave. I think that they thought that they would not be able to ask enough questions. In coming last, I am conscious that most questions have been touched on.

In fairness to the Committee, whatever politics arise in the Chamber, they do not always appear here. You can pick and chose motions if you want to, and I could say that Sinn Féin tabled a motion on tax-varying powers, which nobody supported. We could get into such discussions, but politics rarely come into discussions in this Committee. Indeed, the Committee was the only one to call for its budget to comply with section 75, so we have been proactive.

To come at the issue from a different angle: I do not disagree that health has been underfunded for years, and we need to address that situation. However, how do we get funding back to where is should be? Everybody wants the same outcome, but the differences are in how we get there.

Several people have already agreed that there is wastage in the health sector; we hear about

that, day and daily. Earlier, we attended a lunchtime meeting on diabetes, at which it became apparent that a tweak here and there could make a big difference. If we do not disagree with you, will you come back to the Committee and tell us how the efficiency savings can be implemented in your proposals? You have probably done that already with the Department.

Lily said that the issues of prescription drugs and taxi services may contain scope for savings. Those are valid examples, and we need to find out about them. Most health professionals agree that prevention is vital, which is where Investing for Health comes in. We can move away from taking money from one budget and giving it to another. All the Departments have a role to play in Investing for Health. Patricia mentioned a strategic analysis of the Health Service. We will need more detail on that point later. It is a valid suggestion, but we need to tease out exactly what is meant.

My key question is on Patricia's paper, which lists the radical changes that the unions believe are necessary for the Health Service. What are the views of the Minister and the Department on that issue, because they may be sensitive? You said that, under that framework, there are areas that should not be touched. The Minister's statement has supposedly reassured us that he will not cut front-line care. However, senior managers and chief executives are bringing forward proposals to do that. Let me simplify that: if I were running a business and I told my chief executives that they were not to do something but they did it, there would be consequences. We need to know the Department's views on the framework.

I have further questions, but I see the Chairperson giving me dirty looks.

Ms McKenna:

I do not know for sure, but I suspect that a conversation among the Chief Medical Officer, the Chief Nursing Officer, the senior civil servants responsible for social care and the GPs, together with the Public Health Agency and the Health and Social Care Board and the people, would produce something like this framework.

However, that is not happening. They are currently engaged in firefighting. Everyone needs a breathing space, so a halt needs to be called. That is my main message. I cannot anticipate what they might say, but I hope that there would be strong support for this view. There is some support for it from professionals in the Department. The trusts presented the type of proposals

that they were told not to come back with, and that may be designed partly to make it politically impossible for those decisions to be taken. Knowing the Health Service as I do, I would not dismiss that. Partly, it proclaims that the trusts have gone as far as they can, and beyond that they will protect front-line care. Therefore, it is a bit of both. Teasing out which is which is difficult.

The Chairperson:

The Committee will now have an evidence session with the Ambulance Service. Its representatives have listened with great interest and, perhaps, trepidation to this evidence session.

I thank you for attending and for your willingness to stay and answer a barrage of questions from all sides. This issue will come back time after time. The comprehensive spending review, efficiency savings and budgets are the main issues. Many would say that it is the only issue in town. We have to accept that the Committee's time will be dominated by it. The information that you have provided has been extremely helpful. There was dialogue today, and it will be ongoing for many months to come.

Ms McKeown:

Thank you, and we thank the Committee.