Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Evidence Session with the Health and Social Care Board and the Public Health Agency on the Commissioning Plan 2010-11

3 June 2010

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Mary Bradley
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Mr Sam Gardiner
Mr John McCallister
Mrs Claire McGill
Ms Sue Ramsey

Witnesses:
Mr John Compton) Health and Social Care Board

Dr Eddie Rooney) Public Health Agency

The Chairperson (Mr Wells):

We will now hear evidence from John Compton and Eddie Rooney. Gentlemen, you are season-ticket holders to the Committee, so you must know the routine very well by now. Although I do not think that you need an introduction, I will provide one for the record. Mr Compton is the chief executive of the Health and Social Care Board and Mr Rooney is the chief executive of the

Public Health Agency. The evidence session will take the usual format. Like the previous session with the Minister, you will have 10 minutes in which to make a presentation, after which members will ask a raft of questions.

Mr John Compton (Health and Social Care Board):

My colleague Mr Rooney and I have agreed that I will do the bulk of the presentation and that he will provide a follow-up after I have finished. I will leave copies of the presentation with the Committee. The presentation is a standard one that we have been using to explain the draft commissioning plan.

We are delighted to have the opportunity to speak to the Committee today. We wish to reinforce that the draft commissioning plan remains as such until the Minister gives it his imprimatur. He has been provided with the plan, and it is up to him to endorse it or ask us to make amendments and changes. That is the process, and that is where we are at.

This is the first time that such a plan has been made for the region, and its purpose is to respond to three issues: first, the priorities for action that have been set for us by the Department; secondly, the Department's financial letter telling us about our resources; and, thirdly, the commissioning direction, which tells us how we should operate and provides us with a backcloth and instruction. This is an opportunity for our two organisations, working jointly, to bring our commissioning agenda into the public domain in a simple and straightforward way. I hope that the language used is readable, that nothing is covert, and that the plan in no way avoids addressing some of the real issues about which people want to hear.

The plan was produced as a consequence of elaborate done work by the two organisations and a range of professional staff. That work included senior meetings, briefing meetings for the boards at non-executive level, editorial board meetings, a range of workshops, and work with local commissioning groups. There was a large local commissioning workshop group, which involved all of the members of that group. We also took account of evidence and information from the PCC organisation about stakeholder involvement. The local commissioning groups talked extensively with people in local areas about commissioning and where we are at. We believe that we have made a reasonable start, as far as possible, in the first year of the plan. As the years on go on, we accept that further and more detailed work will be required in the production of the plans. We remain in contact with our colleagues in the Department.

The plan, which, I hope is relatively straightforward, has two sections. The first includes information about the strategic context, the financial context, service users and the important role of local commissioning groups. In the second section, we talk about the priorities for action. I hope that it is readable and that people can get through it.

It is important to bear certain factors in mind when producing documents of this nature. One such factor is overarching themes: for example, what are we trying to say to people about the tent pegs in the ground in respect of how and why we are commissioning? We felt that there were five key points that we wanted to make under overarching themes.

First, we wanted to talk about health improvement, which is largely the remit of my colleague Eddie Rooney. We wish to ensure that we invest money in prevention upstream, thereby helping people to avoid the use of health services. We have changed the dynamic from a sickness service to a health service. Secondly, we wanted to explore the idea of primary care partnerships. We will talk more about that shortly. Thirdly, we wanted to talk about the current configuration of acute hospitals, given all the dynamics that we know exist. Fourthly, we wanted to deal with the overarching issue of living at home. An overwhelming number of people — be they children in vulnerable circumstances, older people living on their own, or those with mental health issues — tell us that they want to stay at home or as close to home as possible.

Finally, it is all right to have all of those factors, but one has to have a context and a sense of investment and financial management. We have accurately and honestly described our financial position.

The health improvement agenda is about making a tangible difference between health and well-being; decreasing the incidence and causes of major illnesses; maximising independent living; and reducing health inequalities, on which we present evidence and social information in the plan that I hope will be revealing and startling. It is also about building sustainable communities, which is very important for us because that is the way to make changes. Finally, it is about having an impact on the full pathway from the community to hospital services, because there is no point in looking at the plan as a set of independent and unrelated activities.

We are very committed to the involvement of primary care, and we are exploring aggressively

with everyone the notion of primary care partnership. That may sound rather sophisticated, and these things can be made as sophisticated as one wants to make them, but we see our local commissioning groups as being bodies that are built around communities of 100,000 give or take 20,000 depending on the geography, rurality or whatever. Those groups will be clinically led, with all of the GPs in the areas and the support of their pharmacy colleagues and other users in the areas. The groups will have real indicative budgets and will begin to get control of pharmacy and prescribing; they will begin to look at outpatients; they will begin to look at diagnostics and community services in an incremental and sequential way.

It will not all happen at once: the first stage will be to establish the groups and the second stage will be to look at prescribing. The real reason for that is that it is the people on the ground who know about things but that, overwhelmingly, we have to better understand demand in our system. The document articulates the changes in demand, but, as I have said, unless one understands the demand, and it is a bit like reading a bank statement at the end of the month: it tells you how much you have spent but you cannot do anything about it. We can tell you what the demand is, but we cannot control it once it is with us. Therefore, it is very important for us to identify demand and give that central role to primary care.

Turning to the acute hospitals; the principal message is that this has precious little to do with money. I cannot emphasise that enough. This has to do with quality. We are having to respond to increased demand, and there are modern treatments, new standards and different workforce patterns. The current configuration of our hospital sector is not sustainable in the long term. We have to look at it and think about it differently.

We talk about building on the Developing Better Services strategy. A key issue, which, as members know, I am personally committed to, is the very strong role for local hospitals. That issue is closely linked to the proposal for primary care partnerships. We are trying to commission local services for local people and safe and sustainable services for the population. That is not an easy message to get across, but it is hugely important. It will mean that there will be a concentration of some services on fewer sites, which is sensible. However, we also go on to say that, not only will we have to concentrate some services on fewer sites, but as a region with a population of 1·7 million, we are not large enough to provide a complete health and social care system. Therefore, we will have to have some partnerships outside Northern Ireland. There are some very some small specialties for which we do not have enough activity to justify generating

infrastructure.

If that is going to happen, we have to change the pattern that happened in elective care whereby large amounts of money were spent in the private sector. The commitment that we gave in our first year of existence to put £25 million of revenue into building current services should have a further £25 million added to it in 2010-11. That will mean that we are beginning to build the infrastructure to enable us to move from our dependence and reliance on the independent sector.

The theme of living at home is about the handling of long-term conditions. Those conditions include ones that members will have heard about many times, such as chronic obstructive pulmonary disease, diabetes and asthma. The theme is about providing a support plan that emphasises recovery. For example, people with mental health issues will not be treated on the basis that they will have those problems for the rest of their lives. Instead, they will be treated as people who are unwell for a period of time and need a recovery model, and we will support that.

We want to see strong partnerships with the voluntary and community sector, more rehabilitation, and we want to move away from institutional care, whether that is long-term institutional care in mental health services, learning disability facilities, or in the patterns and nature of care that we provide to and for older people and children. In the past few years, for children, we have been quite successful in moving away from institutional care and towards foster care.

If those are the themes of the plan, then what are the tools that we have? Clearly, we have our workforce, which I will talk about later, and our resource. We are explicit about our understanding of the resource. We know that we have £105 million less as a result of decisions that were made by the Northern Ireland Executive. We know that there are new and emerging pressures and existing trust pressures. We know that we are in year 3 of the comprehensive spending review and, therefore, at the end point of the 9%. From our point of view, we say quite clearly that when one looks at this as a financial puzzle at the start of the year, one can see that we are grappling with resource of between £275 million and £300 million. The figure that we are working with is £284 million, and the Department, as the commissioning system, has said that £204 million is ours and that it will look after the remaining £80 million. Therefore, our plan is based on £204 million and not £280 million.

One the other side is an investment profile of approximately £118 million. If one has the problem of £204 million, one needs to understand how one is going to solve that problem. We articulate how we are going to solve that problem by year 3 of the comprehensive spending review. That adds up to £58 million and concerns the deferral of funds associated with maintaining existing or planned services and better control of the pharmacy budget through better procurement. That brings us to £204 million, which I am sure members will want to talk about. In the investment profile, we are talking about almost £48 million going into acute services, £40 million to elective care, and £30 million to maintaining our existing services. That gives a total investment profile, in round figures, of £118 million.

In the plan, we make two very important points. The first point is that this is all linked and must be looked at in its totality. It is not something from which we can decide to do one bit and not the other. If we cannot control the £204 million, we cannot invest the £118 million. It is very straightforward. Secondly, because, at the time, the Government had not been elected, the plan was developed ahead of any further changes, and, therefore, reinforces the Minister's position. We are strongly of the view that, if asked to do more, that will have a very material effect on our ability to deliver and commission services as they are currently configured. Of that there is no doubt.

In the past three years, we have had to find 9% efficiency savings, deal with rising demand and deal with an increasingly difficult financial position. If we are asked to find our proportion of the £120 million that is being talked about, we would have to revisit what we are doing and how we are doing it, and there would be material changes as a result of that.

We have articulated the investment profile and made a number of decisions. First, we have decided to spend the money in accordance with the building blocks of the themes in the plan. Secondly, we have decided to spend the money to protect those who are most vulnerable. Therefore, a large amount of money is going to older people, because, given the demography and population change, without that investment, those services will not work and the rest of the system will not work. Money is going to hospital drugs for people with chronic conditions and to the very sophisticated treatments that they require. There will be no double standards whereby some people are getting while others are not. Money is also going to a range of other investments.

We freely acknowledge that many people will be disappointed by the deferral of services. We accept that. However, it is the reality. We have taken the view that it is much better to preserve the service that we have, ensure its robustness, and modestly and moderately continue its development, rather than invest lots of new money in one place and have all sorts of things happening and chaos occurring somewhere else.

Recently, there has been a lot of talk in the press about money. In the plan, we try to tall about that in a balanced manner. We spend about £10 million every 24 hours, and, therefore, for the population, we want a sense of reassurance. There is a very well functioning health and social care system, which is facing an enormous challenge. Our plan states how we should address that challenge.

We go on to talk about how we would deal with public and personal involvement, and we reference the importance of equality and equality schemes as and where required. We also talk about the role of the local commissioning groups and, in particular, the key role that we are expecting from them in commissioning the managing of demographic resourcing and the influencing and developing of primary care partnerships. For the first time, we are giving them responsibility for some of the elective care, with an investment of around £2 million across the Province to look to see whether we can do things at a primary care level that respond responsively to people, but divert them from coming straight to hospital. If that is successful and works well, we will improve on that investment.

The second part of the document focuses on the seven themes and the priorities for action. I do not need to go through them with Committee members as you will have seen and heard them. However, they relate to safety, health status, primary integrated care, and similar sorts of issues.

Dr Eddie Rooney (Public Health Agency):

I will be very brief. Under the legislation, the commissioning plan required the approval of the Public Health Agency (PHA) prior to publication, and that approval was given unanimously last week. The PHA recognises clearly the strong emphasis on the need to prevent ill health and stop that flow into our system. We need to tackle health inequalities in our community and to ensure that the health improvement agenda is followed through for the benefit of the whole system and our communities.

The plan reflects the need to strengthen prevention in a number of its areas. It does it within our health services — and John has talked about the primary care partnerships and the vital role that GPs have in preventable ill health — and in our hospitals with regard to quality and safety. Crucially, however, it does it through our relationship with the 600 community groups that we are involved in funding, which are at the front line of much of the work to help and support communities to deal with issues such as physical activity, nutrition, mental health and the reduction of smoking. It goes right through the commissioning plan priorities.

We have also tried to create some space in pressurised situations to allow some innovation, particularly those that will help to break the cycle of preventable ill health. We have emphasised the stronger relationships with local government. We established a joint unit with Belfast City Council and with the trust, and there is an announcement today about strengthening partnership working in the west. There will be further announcements about our relationship with local councils, in particular, and other partners at local level to try to break that cycle.

We have allowed space for early years intervention in nursing, which is vital in providing intensive support, particularly for the nought-to-two-year-olds. We have evidence of the return for health and well-being through parent support, and we have fine examples of that. Members will be aware of that, not least in St Joseph's Primary School in Slate Street, where parents have a continuing relationship with education. Roots of Empathy is another programme directed towards supporting primary schoolchildren and building the relationship between parents and children through primary-school years. Those are interventions with a strong evidence base, which is an imperative in the plan. We are putting our time and emphasis into supporting those interventions that have the evidence to back them up. On that basis, the PHA regarded this as being a positive first commissioning plan. It is the start of a long road, but a step in the right direction.

The Chairperson:

We all welcome the first commissioning plan for the entire Province of Northern Ireland. It is good news, and we do expect teething problems, as it is a complex document to bring together. It is difficult to do this in a normal financial situation, but it is much more difficult to do it when the goalposts move and, sadly, could move again. I suspect that this will not be the last time that we will be discussing budgets, even in this financial year. It is good news and a major step forward

for the people of Northern Ireland.

Have both boards approved the draft plan? Is that the procedure? If the Minister has no issues, will the draft plan be signed off and become the plan from now on?

Dr Rooney:

Yes; that is the plan.

The Chairperson:

By that stage, 25% of the financial year could have passed.

Mr Compton:

Although that is the case, you will appreciate that one cannot just sit and wait. We have not been sitting and waiting, in that we have recently been meeting with the chief executives of the trusts on a weekly basis. We do not expect circumstances in which the plan could be set to one side in its entirety. We understand that there may well be changes to the plan: nonetheless, we are working on the premise that the plan is substantially complete. It is important that we do that because it allows us to maintain public confidence and control and it gives momentum to the system.

We will not be taking any major decisions, shifts or changes ahead of ministerial agreement. However, we will be managing the process and will not simply wait until we find ourselves a third of the way through the year. Our way of achieving this is that I will chair a project board with my colleague from the agency and some departmental officials. We will have a reporting relationship from the trusts who will report to us about the matters in the plan, particularly finance, so that we are quite clear that the finance is under control. It is very important that the finance remains under control so that we have the ability to respond to a changing financial climate. Those meetings and that system will be fully operational by the end of June and is partly operational as we speak.

The Chairperson:

I am going to deal with some broad issues, but I promised Sue Ramsey that she could ask about detox services. Once we deal with that, and Mary Bradley may want to ask questions as well as that is on her patch, as it were, we will go back to more general issues.

Ms S Ramsey:

I apologise for missing the first part of your presentation. Earlier in the session, the Minister took questions about the Forum for Action on Substance Abuse (FASA) project. There is a letter in members' papers that was sent to the Chairperson about the Derry detox centre. That letter was sent on the back of another death, that of Emmett McFadden. There was an outcry about that. I am concerned about the Minister's views on FASA and the good work that is being done in communities. Chairperson, is it in order to hand that letter over?

The Chairperson:

The Committee has dealt with this. It is a wider issue. I understand some of the constraints that the Health Service is under with respect to people coming into the services a bit worse for wear due to the use of alcohol. It is a real concern.

Mr Compton:

I will try to get the names of the people that I have been working with correct. We have been dealing with Denis Bradley and the whole service in Derry. They have acquired, or have potentially acquired, a site. I have met with them, and they are meeting with the local commissioning group. We have talked to them about the nature of the business case that they might wish to develop, which does incorporate a potential "wet" detox facility.

From our point of view, they have had a signal that we are interested in the issue and that we want to work with them on its development. Paul, the local commissioning group (LCG) officer in the west, along with Brendan O'Hare will be pursuing that. There are no guarantees, but we are making contact with a view to seeing whether we can get some sort of sensible solution.

Dr Rooney:

In relation to FASA, the Department's allocation letter to us has confirmed that resources will be available for a wide range of community involvement, particularly in drug and alcohol misuse and the one-stop-shop concepts that are being piloted at the moment. We wrote to some organisations earlier in the year to make sure that they have enough money to get them over the first couple of months because of the delays in the funding. We will be writing out as quickly as possible to give more stable funding. I cannot say that no organisation will be affected. We have got to do the sums and make sure that we deal with the budget that we have got in the best way

possible. However, as an agency, we will do everything that we can to ensure that those services continue.

Mrs Mary Bradley:

I appreciate what Dr Rooney has said, but the issue has caused a lot of concern in the city, and, unfortunately, a young man lost his life. Although Denis Bradley may now have succeeded in acquiring the land from Derry City Council and is now working hard at getting a detox centre up and running; in the meantime, it would be a gesture that would go down very well with people who have concerns, many of whom have families, and who would appreciate having somewhere to take their young ones immediately. Anything that could be looked at in that context in the meantime would be helpful, although I appreciate what Denis Bradley is doing and he is a very good man for the job.

Mr Compton:

Following receipt of the letter, I have no difficulty in asking the local counselling staff to meet and to talk to the group.

Mrs Mary Bradley:

That would be very welcome.

Ms S Ramsey:

Thank you, Chairperson, for allowing me to speak. Party colleagues and I had a meeting with David Ford during the week on a range of issues, including the pricing of alcohol and on-street drinking, particularly now that we are coming into promotions that coincide with the World Cup. If we are talking about a proactive, positive approach to a lot of such issues, do you plan to meet the Minister? The Committee for Social Development is currently considering a Bill about liquor licences, which is about developing a joined-up approach to a lot of this stuff.

Dr Rooney:

We have been involved in quite a bit of discussion on that, and minimum pricing is an issue which we, as an agency, would like to see addressed, although not in isolation. Like any such measures, legislation alone will not deal with some of the underlying issues, but it is an important part of the jigsaw and the evidence is that it can make a difference.

Ms S Ramsey:

It is important that the Justice Minister is aware of that, because he is preparing material.

Dr Rooney:

Yes, no problem.

Mrs Mary Bradley:

I would appreciate it if the meeting is set up as soon as possible with the group and Denis Bradley. I am sure that that would be very welcome.

Mr Compton:

I will probably speak to the staff tomorrow, and I will set up that meeting as soon as it is practicable thereafter.

Mrs Mary Bradley:

Thank you very much, Mr Compton.

The Chairperson:

The Committee welcomes the priorities for action and the draft commissioning plan, and they are very strategic documents. However, the draft commissioning plan states that detailed delivery plans are not yet ready. When can we expect them?

Mr Compton:

The Minister alluded to the fact that as his confirmation of budget was late, in April, we are behind. Normally, we would have produced our commissioning plans a little sooner than this. We would then invite the trusts to return their detailed responses, which has now happened and their returns will be made by 24 June. These things happen at various levels at the same time. The processes do not wait, because if they were to do so they would not work.

We are already in extensive negotiations with trusts about their service and budget agreements, about which we propose new handling methods this year containing sanctions and incentives. We have signed off the service and budget agreement. Members will see reference in the back of the document to schedules. Those schedules are huge. Members can imagine the number of schedules that we would have to say how many acute admissions there are, and all of

that microscopic detail is in the back of the document.

There is an exchange between the two organisations to agree that and there is a routine, monthly monitoring process to establish whether something is or is not happening, and, if not, why not. The reason may be simply cyclical or it may be an issue that is perfectly explicable. We have decided that at the end of each quarter this year we will take a view on whether we are seeing something different. We may owe the trusts money, because they are doing more work than they expected under their commission. Alternatively, they may owe us money, because they are not doing the work for which we thought we were paying them. We will agree an exchange on that basis, and we have talked about and agreed a 50% change of cost on a given item. That reflects the changing dynamics of this new commissioning and providing arrangement.

The Chairperson:

The schedules in our document are blank. However, are you saying that the documents are there?

Mr Compton:

There are lots of documents.

The Chairperson:

Are they available?

Mr Compton:

Anybody who wants to see them can do so. I genuinely did not think that you would want to trawl through them.

The Chairperson:

As long as we know that they exist, and that they are not —

Mr Compton:

The schedules are at least as thick again if not thicker due to spreadsheets.

The Chairperson:

On page 12, you mention modern treatments and, specifically, 24 procedures that must achieve a 75% day-case rate. What are those 24 procedures?

Mr Compton:

They are to do with scope and camera investigations that people may have, including gynaecological work where, previously, ladies would have been hospital inpatients but where they are now treated as day cases. Our end-of-year performance figures show that we have moved up to 69%, and we are pushing hard to get to 74%. It is an efficient way of doing procedures; it is qualitatively better and patients like it, because it means that they are not in hospital and away from things. In addition, admissions can be planned much more. It covers all specialties. Day cases are done on orthopaedics, gynaecological matters, medicine and other surgical matters all the way through.

The Chairperson:

What is the current rate?

Mr Compton:

Sixty-nine per cent, which is where we finished at the end of the year.

The Chairperson:

Therefore you are not too far off your target.

Mr Compton:

No.

Mr Compton:

We are pushing hard towards the 74% target, and I think that we will be very close to it this year. It required a great deal of re-engineering of how theatres operate, how we deal with individuals and skills training for staff, such as nurse endoscopists, so that they can undertake that invasive procedure.

The Chairperson:

On page 51, on developing better services, you say that the Mater Hospital will eventually become a local hospital. That will sound alarm bells in north and west Belfast. What is the logic behind that?

Mr Compton:

With respect to developing better services, the important thing is not to focus on any individual issue; we will have many debates about what is happening here. To be honest, I suppose that we are looking to work in partnership with the Committee with its support. It starts from the premise that our hospitals cannot continue under their present organisation, and there is no point in pretending that they can.

It is not about money but about workforce, standards, quality and outcomes; therefore we have to ask what we want from our hospitals. There are sensible roles that each facility should have. This is not about closing places all over the shop, which does not work; it is about ascribing proper and responsible roles to each facility. It is about doing that in an orderly and timely way, but with momentum. Nobody is talking about turning the lights off.

For example, we said in the document that we would like what was written in "Developing Better Services" to be substantially in place by 2013; to do that, we have to begin making transitions later this year. For example, going back to the financial scenario where we talked about how we will get the £204 million to balance, there is a line about achieving £15 million of savings through redesigning and reconfiguring services. That £15 million has a full-year effect of closer to £50 million. Therefore if we make efficiencies this year, by next year we will generate efficiencies in their fullest form. We will do that all the way through, and that is very important.

In recent years, as I am sure you are aware, there have been changes in hospitals in Whiteabbey, Magherafelt, Downpatrick, Lagan Valley and the west, and other changes are coming. Sometimes, people think that those changes apply only to small hospitals, but they affect large hospitals as well. Where possible, we want single-site specialties in hospitals. Where two big hospitals are doing similar specialities cheek by jowl, we want all the specialities on one site, not in two places. Those are sensible things that we want to do. The changes are not just about local hospitals; they are as important and as powerful to larger institutions as they are to smaller ones.

The overwhelming view of clinicians is that they want to make changes, not because they want to make things difficult but because they want demonstrably better outcomes for patients. The document contains information on, for example, how well we are doing on cancer, and a large part of that success is because we have reorganised treatment. The document states that

there is a need to look at how and where we deliver emergency surgery. That is very important.

How many sites in Northern Ireland should people be able to go to at 1 am if they need an emergency surgical procedure? How can we organise that safely, responsibly and with senior personnel? There is clear evidence to suggest that surgical procedures out of hours that are carried out by senior personnel have a better outcome than those done by junior personnel.

The Chairperson:

So that we are not always shooting the messenger, I will refer to an example of something that has gone very well: wet macular degeneration treatment — 145 people would be blind had you not introduced that procedure in Altnagelvin and the Royal. It was a tremendous success; congratulations to everyone concerned. There was a 100% success rate, which is absolutely unheard of. However, we are looking at specialist drugs for arthritis. I have direct experience of anti-TNFs. There was an absolutely amazing response. One young girl whom I met in Clough a few years ago could hardly walk, but when I met her the other day I did not recognise her; she is leading a totally active life and is working, earning an income and buying a house.

There are storm clouds ahead for that, because those drugs are expensive. You seem to have problems, as the cost of the treatment is exceeding what you have allocated.

Mr Compton:

That is why we are allocating about £14 million extra for specialist drugs in the coming year to meet demand. Whether that will meet all the demand, we will see as they year progresses; however, we have taken a conscious decision on those specialist drugs for arthritis and wet macular degeneration, as those are life-changing treatments. They have a huge benefit for those who receive them, so we have put the second largest block of money that we have to invest in that arena, because we want to increase the speed of access to those drugs.

The Chairperson:

If a person is already being treated it is fine, but there will be a greatly increased waiting list for those who want to avail of those wonder drugs.

Mr Compton:

Not necessarily. That is why the £14 million is new money. We are already paying for people

who are being treated; the £14 million is to add to that. The £14 million, although it may not cover every circumstance, will allow us to develop at a decent and reasonable pace. Many of those drugs, as I am sure you are aware, are not straightforwardly given to individuals; they require screening, treatments and tests before they can be made available. In deciding, we took the view that it would be quite unacceptable and unethical to say that I am entitled to the drug but that Eddie is not. Therefore we have invested in the development of such treatments. We will see as the years go on whether we have got the demand correct and can deal with it all.

The Chairperson:

My understanding of the priorities for action is that there will be increased waiting lists for those drugs. People will get them, but they will wait longer.

Mr Compton:

That may be the case, but the picture is far from bleak. If the Department is to spend £14 million on those drugs, it is not a bleak picture.

The Chairperson:

I am relieved to hear that. I want to ask about an intriguing issue before I pass on to John McCallister. Page 195 of the commissioning plan states that:

"The regional ICT strategy aspires to having a person centred electronic care record for every citizen".

I cannot help but think of the NHS computer system in GB, which was a monumental failure that cost billions. I hope that we are not doing that.

Mr Compton:

We are not doing that; we want to build on what we have. We have, through our primary-care set-up and our GPs, a very sophisticated system; all GPs have very sophisticated information. We are keen to explore the use of databases. For example, having protocols on measuring blood pressure accurately across Northern Ireland would reduce the incidence of stroke, heart disease and cardiovascular disease.

We want to look at that as best we can throughout Northern Ireland. We have our database information, but we also want an electronic system across the Province; that will not cost billions. Like you, we are acutely aware that one-stop, one-size-fits-all projects have a very poor record of delivery.

The Chairperson:

How much would it cost to deliver that to everyone in Northern Ireland?

Mr Compton:

I prefer not to make a comment this afternoon, but I will write to the Committee.

The Chairperson:

If there were any chance of its failing —

Mr Compton:

No; I assure you that we are balanced and proportionate in our view.

Mr McCallister:

John and Eddie, it is good to see you both again. As the Chairperson said, we will probably focus on budgets for the foreseeable future. How do you keep the trusts to the plan? In the last financial year, some of them were in a very different financial position from others. You have a target of 4·1% for management costs, which some trusts were below.

Mr Compton:

The 4·1% was an attempt to give the Committee an honest figure of what we understand was spent. It was not meant as an average figure; it was what was spent. We can debate bureaucracy and whatnot, but spending 4p in every pound to manage and administer £4 billion worth of expenditure is not unreasonable. We may debate how it is spent, but it is not unreasonable to spend that amount of money.

We were asked by the Minister and the board to take a different role, so we have started to establish meetings with each of the trusts. We have now seen them every week for the past eight weeks or thereabouts, and we will continue to do so. We do a great deal of monitoring, and we have formal meetings about performance, money, quality and other issues from which decisions and actions will flow. We are not here to berate or beat up people; it is, rather, about understanding the issue and taking sensible decisions early to understand where we are. If a trust's performance or financial record shows problems, it is better to understand as early as possible why that is happening so that action can be taken to address the problem.

Mr McCallister:

It will be tough to meet such an ambitious objective across the board.

Mr Compton:

It will be very tough.

Mr McCallister:

The Health Department is the only one that has bought into the project. Is there any sign that other Departments are joining in? Are other Departments buying into the early intervention proposals of the health commissioning plan? Is there any buy-in from the Department of Education? We quizzed its officials last week, and I brought up the point on the public health side about how quick the payback is. They assured us that, in some areas, the payback comes quickly. Generally, however, a public health payback takes much longer. How quickly will your targets start to pay dividends in the Health Service?

Dr Rooney:

I will come to that in a second, but I will start with cross-departmental and cross-sectoral co-operation, which is happening extensively at two levels. At community level, we have some ground-breaking initiatives with the Department of Agriculture and Rural Development (DARD) on rural communities and rural health; we also have strong relationships with the Department for Social Development (DSD), the Housing Executive and the Department of Education. That is reflected in community projects throughout every county.

Strategically, we also talk a great deal. In fact, we are all meeting tomorrow to pool our experiences of tackling the inequalities that are on everybody's agenda. Regardless of whether we put a health, education or social label on inequality, it affects the same people in the same areas. We know where they are and how they fare with regard to their participation in society and the benefits that they get or do not get.

There is a coming together of minds. That will be reinforced in Investing for Health, which was mentioned earlier, and its review, in which I am involved along with the Minister and many other parties. It presents an opportunity to consolidate what we have learnt. Its message is that everyone has welcomed co-operation; however, we want to do more. There is willingness

throughout the system to do that; not least for you, because it will be copper-fastened in the Assembly and in the joined-up government element of the next Programme for Government. We are all working under that framework from the past. We have learnt a great deal, and there are strong examples of local co-operation and willingness to do more.

As regards dividends and how long it will take to show payback from prevention, in some areas it does not take long; when you provide a new service, you get rapid turnaround. However, for certain services, that is not the case. At most, a generation can pass before the full benefits of some services are seen. The steps towards that can be seen in the increasing evidence base. In some initiatives that I mentioned earlier, particularly early years intervention, we have the best research base internationally with regard to the turn-around period. It can take three to five years before one sees benefits in health and social indicators.

My difficulty in an environment of financial pressure is always to ensure that emphasis on investing in prevention — to stop the flow in the first place — is not set aside while everyone works on the issue of the day. In many ways, the draft commissioning plan reflects that because the broad range of services needed by the population needs to be addressed. We are saying: for goodness' sake, do not fail to back prevention, which can make the biggest difference and give the biggest return in the long run.

Mr McCallister:

I suppose that that covers some of my points. While we wait for the Department of Education's early years strategy, I am concerned about whether it has had enough health input. I am encouraged to hear that work is ongoing.

On 27 May 2010, we were told that the plan has not factored in much of the 9% or 10% rise in demand that has occurred during the past couple of years. Presumably, the Department says that it does not anticipate as big a rise in demand. What will happen to the plan and the budget if that rise occurs?

Mr Compton:

The point of the plan is to say that we have to do things differently and that change is coming. If we leave the organisation of services as it is, services will be unable to deal with different patterns of demand. For example, if we move day cases from 69% to 74%, or the average stay in hospital

down by half a day because we get the systems more correct, we can absorb demand. To some extent, that has happened during the past number of years.

It is increasingly important for us to see that happen. That is why, in primary-care partnerships in particular, we are keen to look at how we deal with demand. Some interesting pilot work on that is going on. That is all that one can say about it at present, because it is in its early stages. However, it is an interesting commentary on how we handle demand. We understand demand. It is not that we should not respond to people who have issues; we must ensure that people go to the right place for their treatment, response or support. That is the important issue.

Change is coming. The fact is that professional standards and clinical outcomes improve if we organise ourselves differently. That is why we are explicit in the plan that maintaining the status quo is no longer an option.

Mr McCallister:

You need all those systems; you cannot move people out of a hospital if they have nowhere to go.

Mr Compton:

Absolutely; it is connected. That is why, in the performance management of organisations we look not only at elective waiting times but at discharge rates within 48 hours for complex patients. We need to know how often it takes longer than 48 hours to discharge a patient and to understand why that happens. To push up the length of stay is bad for the quality of care for the individual, bad for the hospital and bad for the system. Performance management is not designed to tick boxes, because that is pointless; it is designed to add value to how we work. We must be able to assure ourselves that that is what we are doing.

Mr McCallister:

The community and voluntary sectors are involved. Many argue that that is a way of building in savings, because those services can be delivered more cheaply. Are you committed to that, but without reducing quality?

Mr Compton:

Yes. It is important that we work in partnership with the community and voluntary sectors. It

would be wrong to start from the premise that we should ask another organisation to do something for us because it can do it more cheaply than we can. In order to work with the community and voluntary sectors, we must understand their capacity, our requirements and capacity and what we deliver, and from that we can achieve a sense of partnership.

We have no difficulty in working extensively with those organisations, which, broadly speaking, fall into two groups: those that have what we call community capacity we typically support with sums of £25,000 a year or less — often substantially less; there are also the large providing organisations with which we contract to provide large elements of service. The relationship with those organisations is different, and we expect a performance regime from them that is similar to that which we expect from our own services. We are keen to work in partnership.

Mr McCallister:

Can you ensure that the tendering process for those organisations is on a level playing field and that you are getting the best value?

Mr Compton:

Absolutely. There is no desire on our part to describe any of that in an imbalanced way that would show preference for a result to be in one place or another; we are interested only in the quality of service and its value for money. We are not interested in slavishly following it one way or the other.

The Chairperson:

If we carry on as we have been doing, we will be finished by 6.45 pm. I do not want to put pressure on anyone, but we still have to discuss the Sunbeds Bill and the statutory rule.

Dr Deeny:

I thank Eddie and John for being here and I apologise for missing some of the discussion. I hope that I am not going to drag you across issues that you have already covered. I will try to be as brief as I can. I declare an interest as a GP and as a member of a local commissioning group.

First, I want to address some practical issues. I have heard about primary-care partnerships. I do not know whether the word "partnerships" is a good idea, because we already have

partnerships in medical practices; that might lead to confusion when it comes to legally binding business contracts. I also read about primary-care federations, and I do not know whether that is a suitable term or not. In practical terms, however, we are talking about 100,000 patients and roughly 1,700 or 2,000 patients per GP; therefore we are talking about 50 GPs.

There are many difficulties, as I am sure you know; you are men of the world. There can be personality clashes. I am concerned that there are differences across practices, for example, in prescribing. Some prescribe generic drugs well; some do not. Referrals are being looked at now. I am worried that this is about making everyone the same. We do not want to do that; we do not want to pull down good practices at the expense of others.

Why are we going down this route? We are talking about referrals and generic prescribing. The public will see that as a way of saving money. However, that cannot be the sole reason. To incentivise GPs, primary-care professionals and practices into doing this, we must invest in local communities. Tell me that that is not the primary reason why we are doing this.

Mr Compton:

The primary reason is definitely not to do with money; it is to do with quality outcome and demand. Value for money is also important; I do not deny that that is an issue. However, that is a slightly different debate from talking about this as a cash issue.

Why do we want to do it in this way? First, people said that they would like it done this way; therefore this has not been just dreamt up without input from primary care. Secondly, it is something we want to explore, not something we are definitively saying must be done. That does not work, as I am sure you know, in primary-care land. Furthermore, it is about connecting decision making; if there is a money issue, it is connecting decision making to resource allocation. That is very important. The more people we have who know the world and are connected to how money is spent, the better for us all, patients and families. We have a proposal on how we should handle it that will be shared with all the appropriate bodies, the professional bodies and groups; the LCGs will be influential in how that develops.

This is a tremendous opportunity for primary care to get a leadership role in the delivery of health and social care. For many years, I heard from primary care that it had no voice in influencing big decisions. This is a good opportunity to have that influence, authority and

presence.

Will this be straightforward or easy? No; we will have to work with everyone to do it. It is certainly not about sameness, and it is definitely not about dumbing down: if anything, it is the reverse. It is about improving standards and changing how we do things, providing services and raising our quality to the best rather than dropping it to the worst — far from it. To do it the other way is a complete no-no.

Dr Deeny:

I am glad of that reassurance. You are confident that you will get over all the pressure and problems?

Mr Compton:

I do not know; we will wait and see.

Dr Deeny:

You said at the start of your presentation that this was not about money. There are not many people in healthcare provision and management who would say that it was. You say that it is more about quality. That is good to hear.

Mr Compton:

It is absolutely about quality.

Dr Deeny:

You also talked about organising differently and working better. That is all good talk. You spoke about local hospitals. People know that there cannot be acute hospitals everywhere, but as I said earlier to the Health Minister, we would like consistency in local hospitals across Northern Ireland. The local hospital in Downpatrick might serve as a model; the Committee visited it and was impressed. We heard that it is much less expensive than what is proposed for Omagh. Since the trusts seem sure that that hospital will work, could that be rolled out as a model for local hospitals?

This next question is of interest to the Chairperson, so I know that he will let me ask it. It is important to anyone who lives in rural areas. I have seen this work in Scotland, and I speak as a doctor, challenging my own profession. If we are to be realistic in providing the services that

rural people need, we must look at networking and rotation of staff. That is happening in Scotland, where there are six rural hospitals. They can do that because consultants can give time to country hospitals, although I do not know how far those consultants have to travel, how their contracts are framed or how they work.

Can we be brave enough to tell consultants that Belfast is not the be all and end all? We need to tell them that they are being well paid. Sue often says that when she speaks about doctors' pay; however, that is for another meeting.

Ms S Ramsey:

Take it personally if you do not like it.

Dr Deeny:

When people in good positions are paid good salaries and are trained in university at taxpayers' expense, perhaps they should be asked to commit to providing the services that are needed in other parts of Northern Ireland and not just in the capital.

Mr Compton:

We agree with much of that. For example, we have a much closer relationship with the training body and, at our behest, it has changed the rules with regard to junior training. It now makes the case that if people apply for a training post and get that training post, and another training post comes up and they apply for it, they used to be able to jump ship with no consequences. Now, they lose the training time; they now have to sacrifice time if they wish to make the move. That relates to stability and understanding their obligations. We have obligations to train people properly and responsibly; equally, people have obligations to run a service. It is a matter of proportion and balance, which is, essentially, what you are talking about.

In future, hospitals will move towards networks. We looked at urological issues last year, and we invested money into three inpatient centres. That means that if patients are in a hospital where there is no urological speciality, they will see a urologist the morning after they have been admitted who will then decide what is best. They may be retained in a local environment or be sent to a central hospital. That is proper networking; it means that the expert will be out in the local community as well as in the central hospital; that is a way forward in developing services. That model has worked successfully, although not everyone agrees with it; however, we have

been through it and have consulted on it. The Minister has agreed it, and we are putting it in place.

There are tangible expressions of things being different. I am committed to local hospitals, as they add a great deal to the system, and 70% of people's needs can be met locally. I know that the contentious bit of the local hospital is the front door and beds. Nobody every fights about x-ray, outpatients or day cases: people fight about beds and the front door of a hospital. It is our collective responsibility to be sensible about those two issues; we should not maintain systems that cannot do what it says over the door. There is nothing worse than people arriving at an accident and emergency department that cannot deal with their problem: staff know what is wrong but they cannot do anything and people have to be repatriated to another hospital. That is not a good situation for people to be in. I am talking generally about people who are very ill for whom time is vital.

We need to have a responsible, mature debate about what is achievable in A&E. The language of accident and emergency is what everybody understands and what everybody uses. An emergency department deals with three things: minor, intermediate and serious cases. We need to be clear about what we are asking emergency departments to do. Our inability to communicate clarity puts professionals in difficult spots. They do not want to work in a difficult spot: why should they have to deal with an emergency at ten o'clock at night that they should not have to deal with?

Dr Deeny:

That is the problem. I know that we need a large population to have a full-blown A&E department. However, some local hospitals can treat and stabilise patients so that they can be moved on; other local hospitals will not have that facility. For example, I am aware of a child who was having a fit being driven past a local hospital, and the ambulance man was in an awful state. That is one of many examples. We cannot have local hospitals called the same yet their services dependent on their postcode.

Mr Compton:

I accept that. However, most bypass protocols now mean that the Ambulance Service takes all paediatric emergencies past local hospitals. All injuries that present or look as though they are traumatic, perhaps those resulting from road traffic accidents, are taken to the centre where the

expertise can deliver the best outcomes. There is a solid body of evidence that that approach produces a better outcome. That does not mean that there should not be a local facility that people can go to. The debate is what and how.

The only difference between my view and yours is that I think that it is difficult to clone identical local hospitals across a place such as Northern Ireland because, by definition, communities are slightly different. About 70% of a local hospital can be the same everywhere, but a bit of tailoring must be allowed so that a local hospital reflects local issues and the local arena more accurately. That is what makes local hospitals successful, but 70% of each hospital should be the same.

The Chairperson:

I need to nip out for 10 minutes. In the absence of the Deputy Chairperson, I have asked Alex Easton to hold the fort; he seems to be our resident sub. Are folk are happy with that?

Mr Gallagher:

The meeting might be over when you come back.

Members indicated assent.

(The Acting Chairperson [Mr Easton] in the Chair.)

The Acting Chairperson (Mr Easton):

You are in trouble now, John.

You said that you are taking £25 million out of the independent sector and putting it back in. Are you building up enough resources to cope with getting rid of that £25 million?

Mr Compton:

We said in the investment profile that £40 million will go into elective care. In the 2009-2010 financial year we committed £25 million of the elective care money recurrently to build capacity. That capacity will not be built up overnight because it is about recruiting consultants and specialist staff. We believe that that capacity will be substantially on the ground in 2010-11. We will do exactly the same in 2010-11 so that we will substantively have another £24 million worth

of recurrent investment for 2011-2012.

The object is to move away from using the independent sector towards a more balanced proportion. We will always need bits and pieces of the independent sector, but we need to create the right balance. We have the resources in the plan and have made those commitments.

The Acting Chairperson:
Will you clarify that every penny that is taken out of the independent sector will go back in?

Mr Compton:
Yes; there is no question about it. That is absolutely the case.

Mr Gallagher:
Thank you for your presentation. A great deal of work and thought have obviously gone into the plans.

You talked about emergency surgery facilities. That will always be a difficult matter, but time and distance are crucial. In an emergency, people in Belfast or Derry can at least get to a hospital in reasonable time; it is different for people in remote parts of Fermanagh and Tyrone. Someone may be bleeding heavily from a ruptured artery, for example, and time is critical. Will that come into your thinking?

Mr Compton:
Absolutely. We will take professional advice on all those matters.

Mr Gallagher:
Everyone seems keen to address inequalities at long last. Do you have a role in that? You have a role in funding trusts' delivery of services, for example. If one trust has a long waiting list for occupational therapy referrals and another does not — and there are many other examples of such inequalities — can the board input on the delivery of that?

Mr Compton:
Absolutely.

Mr Gallagher:

How does that work?

Mr Compton:

The board meets the trusts monthly to go through their performance against priorities for action and actual performance targets; if, for example, waiting times were drifting in one organisation and not in another, the board would demand an explanation. There may be a perfectly logical explanation, but the board would accept it only if the drift were corrected in time. If there was persistent failure, the board may ask staff to go into the organisation to establish why that had happened. There is a significant involvement on the part of the board to ensure that there is equivalence across the trusts, and the board reports publicly each month on performances.

Mrs M Bradley:

I will be brief. John, you spoke earlier about elderly people who wanted to be cared for and nursed at home, and I like what I read in your plan. However, will it mean that someone will visit elderly patients for 15 minutes each day and that they will see no one else for the rest of that day?

Mr Compton:

No. I hear that all the time, but it is not what we want if people are to be cared for at home. The board is spending a huge amount on providing that care.

Our older population is placing big demands on the system; that is why I am keen for people to have control of the money. One of the questions that we should be asking our older people is what makes their lives work, not telling them that they have to accept whatever we can afford to give them. I listened earlier when others said that people do not want to take on that responsibility, but there is a tremendous opportunity for communities to become involved in the process, to have influence and take on that person-centred responsibility on behalf of people in a community. Indeed, the provider organisations are very keen to have that person-centred, direct-payment approach; it is a matter of getting the right method to implement it. It is the way forward. I do not want to preside over a service that is uncaring, as you have described it. The Health Service is meant to have care at its core.

Mrs M Bradley:

Not every older person has the luxury of a caring relative.

Mr Compton:

That is why our communities must think more imaginatively about how direct payments are handled and supported. There are examples of when it has worked in the past.

Mrs M Bradley:

I should have declared an interest earlier: I work with a resource centre that looks after old people and which works with the board.

Ms S Ramsey:

Picking up on Mary's point, we must look to other Departments. Groups such as Good Morning Galliagh and Good Morning West Belfast do very good work, but they are funded by another Department and must work hard to get that funding. They are proactive, and their work saves the Health Service money in the long term.

I am glad that you have now become a gamekeeper, John. *[Laughter.]* However, where is the accountability mechanism? If a settlement is reached on the back of what the Department and the Executive want and the trusts do not implement those actions, it will have been a waste of public money. Public money has been spent for a long time with no one being held responsible for where it is spent, and a postcode lottery was created as a result. How will the accountability and the penalties for non-compliance operate?

On the issue of financial pressures, two health services operate on this small island. Developing the points that Tommy made earlier, is any proactive work being done by the two services, particularly in border areas?

Page 160 of the draft report states that:

"Trusts should ensure that appropriate Transitions services for young people with a disability and their carers are in place".

That is not happening, but I will give you the benefit of the doubt that it will happen. However, saying that trust will "ensure" that it happens does not strike me as the same as saying that trusts "must" do it. It is easier to motivate people when you talk about acute services versus the Cinderella services. Where do the health and education sectors fit in to that transition? People receive a good service until they are 18, but when they make the change from a child to an adult,

they are more or less abandoned.

Mr Compton:

Co-operation and Working Together (CAWT) helps with very large amounts of money, and the two jurisdictions can use European funding. We work extensively with CAWT from what could be described as hard-end acute hospital services through to local community services, where people are straddling a line in a road and the jurisdiction might be in question. As the commissioning organisation, we have no difficulty in working with colleagues in any other jurisdiction, and if we can work for our mutual benefit, we will explore those options as best we can.

The Minister made it clear that he sees us as the commissioning system and as the organisation that is accountable for the delivery of the plan and accountable for how we operate with the trusts. If there is a major failing in how that is provided, accountability rests with us. That change has taken us into a new, much better, relationship with providing organisations. It is not about one side versus the other; it is merely a clearer relationship. The Minister remains in control, as any Minister would rightly want to; that is how a devolved Administration should operate. The Minister should be supported by his Department, which will advise him on policy and so on. He has made it clear that he is increasingly looking to us to deliver and that he will hold us to account for that delivery.

Ms S Ramsey:

What about the transition arrangements?

Mr Compton:

We expect people to have proper transitional arrangements. The language in the document is meant to be strong; if it is not, we will reflect on that. The arrangement is meant to be non-optional. As people leave schools, including special schools, they are expected to have a proper planned arrangement, and my understanding is that there are joined-up arrangements with the education sector and social services. I fully accept that they may not always deliver, but there is meant to be straightforward communication between bodies to identify individuals who are transferring and to discuss the most appropriate way to handle their transfer. Of course, it is not always or exclusively the obligation of the health sector to provide that service; sometimes the employment and further education sector is equally important.

Ms S Ramsey:

I have a case that you will find very interesting.

Mr Compton:

I am happy to deal with the detail.

Ms S Ramsey:

When the child concerned reaches 18, the respite falls from 52 days to a couple of days. I will copy the detail to you.

Mrs McGill:

Transition, learning disability and the availability of placements for young adults at 18 and 19 years are my key concerns. There is a dearth of placements in the Strabane District Council area. We are being lobbied on that matter, and I, and others, have raised it repeatedly. I asked the Minister earlier about a newbuild for Glenside, which seems to be nowhere on the register; he could find no evidence that it had been prioritised. John, as you are the commissioner, perhaps you could tell me who eventually prioritises such funding.

I want to make a connexion between what we read in all the documentation about deprivation and poverty and putting in extra resourcing to address that issue across populations and geographical areas. However, having looked at the documents, I am not convinced that everyone is sufficiently of the view that there is deprivation; but deprivation exists in the area that I represent and in other areas. I should declare an interest as a member of Strabane District Council. Instead of increased resourcing, in many cases there seems to be a reduction. I will speak later about the meeting in Limavady last night about the out-of-hours service of which Limavady and Strabane have been stripped. I am not saying that at this stage one model is better than the other, but the feeling at the meeting last night was that there is a reduction in services in Limavady and Strabane. I am based in the Strabane area, and I was very glad to be there last night to hear the discussions.

I do not see enough emphasis in the commissioning plan about addressing health inequalities, deprivation, and historical under-resourcing. As we heard at the lunchtime meeting with the group from Omagh, there are 166,000 people in Tyrone and there is no hospital, although there

are hospitals elsewhere. What is the ambulance situation? Sixty-seven per cent of calls are responded to within eight minutes. Kieran mentioned the rural areas. That 67% is close to the target of eight minutes, but it is never analysed; at least I have not seen an analysis of it. Where does it cover? The remaining 33% could be 100% that do not achieve the target in the rural area. Although the 67% may meet the target, if it were further analysed it could indicate that that comes out of the urban figures. Given the reduction of services in rural areas and the deprivation and poverty, that is something that needs to be looked at.

I have one other question; I will take brief answers, or you can come back to me with them. In relation to the cancer targets and referrals, breast cancer referrals are seen within 14 days, and 98% of cancer patients commence treatment within 31 days of the decision to treat. Adding 31 to 14 gives something over 40; is that the case? The definitive treatment then starts within 62 days — 62 days of what? Are those 62 days added to the 45? What if it happened to be urgent? It seems to me to be not that urgent in relation to those figures.

The plan from the local commissioning group is not available at this stage; it will be produced some time d this year. How have we arrived at the figures that we have at this stage? We have a local commissioner present — Kieran Deeny. Are deprivation, inequality and poverty highlighted when you meet the local commissioners? If they are not, there is a problem.

I want to spend a bit of time on the issue of the out-of-hours service, because at the meeting last night I gave some commitment that it would be raised today, with the Chairperson's approval. I want to quote from a briefing —

The Acting Chairperson:

Can we just stick to some questions?

Mrs McGill:

This is an important issue. It is the end of the session, and other members raised issues that were discussed at length. I represent an area in which there are health inequalities and unequal outcomes. I would not want there to be an unequal outcome from this Committee due to the time for which I was allowed to speak.

The Acting Chairperson:

You are doing well for time.

Mrs McGill:

Strabane has no out-of-hours doctor and is covered by Derry; no doctor based is Limavady, and it is also covered by Derry. I have a briefing note in which a GP from the area makes the point that a doctor could have to travel from Magilligan to Castlederg, which is in my area, and back again. In his view, that is not an effective use of time. Are there drivers and nurses waiting somewhere to be called on to travel with that doctor?

Finally, at last night's meeting on out-of-hours cover in Limavady, there was much passion, similar to that which I saw at a previous meeting in Strabane. Out-of-hours provision and its value have to be analysed fully; there is much to be done. I asked the Minister whether it might be a good idea to postpone the proposal in Strabane and Limavady if the nurses were not fully trained — and apparently they will not be until September — as there could be health and safety issues.

Dr Rooney:

John can answer your questions on service response and I will talk about inequality. Whether there are health inequalities is beyond debate. However, the key question, as you said, is why there are health inequalities. The evidence shows that inequality affects people's lives. The latest government figures show the gap between areas of high deprivation and areas of low deprivation, which are often only a few hundreds yards apart: there are twice the number of deaths from smoking, three times the number of suicides, four times the incidence of heart-and-lung disease and five times the number of alcohol- and drug-related deaths. That is a phenomenal gap. Life expectancy and death from coronary heart disease, for example, are going in the right direction, but in deprived areas they are widening.

There is no question that a problem exists; however, dealing with it is not easy, because it requires a two-level approach. There is a basic issue around service response, which is John's territory. However, dealing with some of the underlying issues takes in poverty, the nature of our society, and some very tough areas that we cannot paper over or deal with instantly. However, deal with them we must. Narrowing the gap will go a phenomenal way towards achieving a better Health Service, having more resources to put into the care sector and making sure that

people — because we do not want people in hospital if they do not have to be there — are fit and well at home. To do that, we have to deal with communities on their terms and deal with the situation from the bottom up. We will deal with the wider issues at the same time as dealing with the immediate service issues, but I cannot take my eye off that ball.

Health inequality hugely affects our citizens. Some of the issues are long-term and complex, involving not just the health sector but other sectors. Therefore, it must be dealt with on all fronts. Everybody, including local commissioning groups, listens to me whether they want to or not, and every time I speak they hear the figures. The response has been very positive. I know from discussions that this is a big issue, and one with which we struggle. However, it is high on the agenda and we have to see it through.

Mrs McGill:

I welcome that positive response, although that is what I would expect. Does that translate into action on the ground? The spending on respite care has increased by 0·6%, which I welcome. However, in his briefing earlier, the Minister said that there would probably be a reduction in funding for respite care, which is worrying.

I want to go back to the issues that affect the learning disability community in the Strabane area. Elderly carers are crying out for respite packages, but they are not available. Given that the same issues are raised each time in your discussions, your words must be transferred into action and funding.

Given the budget and all the difficulties that surround it, who has the final decision to match the priorities contained in the documents with the necessary funding?

Dr Rooney:

If you take a walk through Melvin Park, which is in your neck of the woods, you will see the allotment that I, along with Jarlath McNulty, was involved in opening a couple of months ago. Beside that allotment are playing fields that used to be dumps. Those fields are now being reactivated and reclaimed by the community.

Outdoor physical activity has been built around the redevelopment. We are starting to see communities taking responsibility to regenerate themselves. We have a responsibility to support

that and help to make it happen. In doing so, we tie in education, nutrition and physical activity, which are the practical building blocks. That is my focus.

However, I accept the point that we must not take our eye off ensuring that the immediate issues of concern and the importance of equal access are also fundamental parts of what we do. Strong building blocks are being put down in communities. There are not enough of them, and it will be hard to work with the level of funding that the Minister mentioned, but we must keep going, build them higher and ensure that sufficient community capacity exists.

Mr Compton:
I have about six questions to answer.

Mrs McGill:
I will accept brief answers, and you may come back to me with more detail.

Mr Compton:
Ok, thanks.

First, funding is allocated according to the capitation formula. The draft commissioning plan outlines exactly where the funding is allocated, and the Western Trust receives its fair share. Although the Southern Trust's share is slightly lower than it should be, no area's funding is a mile away from what it ought to be.

Our total pot of money is allocated by using a formula that asks how many people live in an area and takes account of rural, age and deprivation factors. The formula is well researched and bona fide. That is how we arrived at the decision to spend 17·1% of the money that we receive in the Western Trust area.

Mrs McGill:
The Northern Trust area receives 24·3% of the total funding.

Mr Compton:
It covers a larger area and has more people.

Mrs McGill:

Is the Western Trust area not more deprived than the Northern Trust area?

Mr Compton:

No one factor determines the allocation. There are a range of factors, including the absolute numbers of people and the age structure of a population, which takes account of how many people in an area are aged over 65, 75 and 85 and how many children are aged under five. The formula carries with it a range of other issues, including the number of people with disabilities.

The formula is well known and well established, and it is a bona fide arrangement. It has been consulted on, and no one has significantly disputed it as a method of allocating funding. Some tweaks may have been suggested, but no one has disputed it in principle.

Mrs McGill:

John, will you confirm that, according to figure 6 in the draft commissioning plan, the Western Trust area receives the lowest percentage of any commissioning area? Am I reading that correctly?

Mr Compton:

Yes, but you cannot draw any conclusions from that.

Mrs McGill:

You just did.

Mr Compton:

You cannot conclude that, because the Western Trust receives the smallest percentage, it gets less than its fair share.

Mrs McGill:

The capitation formula was used. Some detail has been given on how you arrived at the figure of 17·1 % for the Western Trust, but I am still unclear and would welcome more detail.

Mr Compton:

OK. That is fine. I will provide that to you.

Your second point was about learning disability in Glenside. Given that it is a local issue, it would be best for you to meet and raise the issue with Paul Cavanagh and Brendan O'Hare, who are members of the local commissioning group. I encourage you to do that.

Your third point was about ambulances. The ambulances figures are recorded geographically. The emergency response times from the Belfast Trust are not combined with those in the Western Trust to create an average. We insist on the ambulance times being recorded geographically.

Mrs McGill:

Given those figures, do you accept that people in rural areas may be disadvantaged?

Mr Compton:

The Northern Trust area persistently has the most difficulty in meeting the standards.

The progress on cancer targets is a fantastic news story. The evidence that we publish relates not only to prevention and education, which is Eddie Rooney's world, but shows the progress being made in dealing with cancer. Claire, you talked about the 14-day target, but you should not regard the targets as cumulative. Most ladies, for example, receive a date for surgery on the day on which the diagnosis was made or soon thereafter. Most people receive that treatment inside 30 days. That is a good news story in respect of how we are progressing treatment and treating those who are most seriously ill.

I had a feeling that you were going to ask me about out-of-hours cover, so I put together some information. In the Western Trust area, on average, 37 patients are seen after midnight, 18 of whom require face-to-face contact. Limavady has the lowest requirement. Currently, there are five GPs, one in each of the five locations. The proposal is to have three mobile GPs, but retain the five locations, so that people can still be seen locally.

Mrs McGill:

Do you accept that the doctors are based in Omagh and at the Erne Hospital?

Mr Compton:

Doctors will be mobile throughout the area. I will explain how the system works elsewhere,

because that might be helpful. A system similar to the one planned for the Western Trust works in the Northern Trust. That trust, which is larger, has two doctors on duty at night, and there have not been any difficulties or serious untoward incidents. That system has been running for some considerable time without any problems. A similar transition, therefore, has already been made in a much larger geographic area.

In your area, Claire, there will be three GPs as opposed to two, because we recognise that some of the road infrastructure in the Western Trust area is not as good as that in the Northern Trust area. We will use a system that is based on a proven model, as opposed to being just a good idea. We know that the system works well and that it has done so throughout that period. I am not aware of any issues with training staff. It is my understanding that the scheme is ready to start on 1 July 2010. However, given your comments, I will double-check that. The scheme has nothing to do with saving money; such schemes rarely do.

Mrs McGill:
After you double-check, what will you do?

Mr Compton:
I will double-check to find out whether my information is correct. My understanding is diametrically opposed to yours. However, if I discover something different, I will have to think about what should be done.

We have £3·2 million a year to run the out-of-hours service in the Western Trust. Last year, however, we had to spend £5·6 million to run the service. We, therefore, had to put money into that service, which deals with 37 calls and 18 face-to-face contacts after midnight. That is the kind of decision that must be taken when properly and responsibly connecting value for money with clinical outcome. It is not about the cash: no one takes a single penny. The money is provided simply to run that out-of-hours service. We simply prevented the trust from spending a whole pile of money that it did not have on running the service.

We have to meet the quality standards that apply in Northern Ireland. We have been running the same system in the Northern Trust area as the one that is proposed for the Western Trust area and have not failed to meet those quality standards. I am advised that we are completely confident that we will also meet the quality standards in the Western Trust area. We must take

into account a variety of factors: our ability to meet the quality standards and still get value for money; whether we can respond to the level of need; and whether we can operate the system in a proportionate and, I hope, sensitive manner. We have taken all those factors into account in our approach.

The decision was not made in 24 hours. Sensibly, considerable discussion took place for some time. If the new system does not work, we will, of course, change it. We always commit to monitoring new schemes or systems after their implementation. If it turns out that the Northern Trust model does not work in the Western Trust for some reason, we will re-examine the situation. It is not our desire to leave the population of that area without access to an emergency general practitioner.

The Chairperson:

Claire, you have probably broken the record for the largest amount of time given to a single stint of questioning, but I know that you feel strongly about those issues.

Mrs McGill:

Thank you.

Mr Buchanan:

The commissioning plan is full of targets but sets no time for their delivery. It states that the trusts or commissioning bodies "should" but not that they must deliver. The trusts could respond by saying that they were not in a position to deliver on certain targets. The plan is not binding on them, and, therefore, there is room for significant slippage.

Mr Compton:

Perhaps the language is not explicit, but you must understand that the plan is binding on the trusts.

Mr Buchanan:

Who will monitor its implementation by the trusts?

Mr Compton:

That is the board's responsibility. We have a further document that is almost the same size as the

plan. It is our first draft, because it must be validated according to the position at the end of last year. However, I can tell you how each organisation performed done against each targets and whether the targets were achieved. That document has led to some difficult conversations between our organisation and some of the providing trusts. That is why we are moving towards responsible — I emphasise the word "responsible" — incentives and sanctions.

You are right that there is no point simply stating that it would be great if something were to happen. I go back to the fact that the Minister has asked us, as a commissioning system, significantly to increase our engagement with the providing system and to take action as required.

Mr Buchanan:

You have repeatedly stated that the focus is not on money but on the quality of service and design management that can be achieved within your resource allocations. However, that is a way of masking the real issue. The fact is that the trusts receive a smaller pot of money each time, and, as they must work within their resource allocations, they have to redesign their services. That is why services are being redesigned throughout the various trust areas.

Mr Compton:

It is complicated. Value for money is, unquestionably, an issue. However, from a commissioning point of view, we were given £3·6 billion to buy services this year, and our job is to get as much as we can for that. However, if we need £4 billion to deliver the services, that is your job. We are obligated to do the best that we can with the money that we are given, and we do so with proper attention to quality, volume and value for money.

We have said explicitly that, if we take a decision to make a cut, we will tell you so — straight up. In fact, we emboldened that statement in the plan. There will be no messing around, no back doors and no fudging. If we plan 100 projects and changes to the budget allow us only 90, I will tell you that we have 10 fewer. We are upfront about that: we do not try to hide away.

Often, the discussion is controversial. When we talk about money, everyone immediately rushes to use the "cuts" word. There is a difference in the use of language. If the money that we are given allows us to go ahead with only 110 of 120 planned projects, some people would refer to that as a cut, but we would not. If I return to the Committee to talk about a cut, it will be because we are implementing only 90 projects, not 100. I will use the word "cut" when we have

stopped doing something that we used to do.

The other important issue to get our heads round is that of locations and populations. My job as a commissioner is to ask whether a population has access to the service in a timely, professional way that produces good outcomes. That does not always mean that the service has to be provided in a specific location.

Take the recent example of Magherafelt: the man or woman in the street might say that the service has been cut, but I do not think for one second that that is the case. I would argue to and with anyone that there has been a proper, responsible service improvement. No one, but no one, in that area is being denied access to an accident and emergency service. If a population had no access to an accident and emergency service, that would be a different matter, and I would say so.

In is interesting to examine how populations behave. People often choose not to have surgery in their local area. That may be easier to observe in acute services, but it also applies to social care. However, if we were to make a change to the surgical service in that area, some would say that we were cutting a service.

It is complicated, but the point that we wanted to make in our plan was that, if a situation exists in which we do not provide a service or have to cut a service, we will be 100% explicit about that. As I said, if we face further financial challenges as a result of the new Government, we will be back here to tell the Committee not about reshaping or service design, but about cuts.

The Chairperson:

Earlier, I asked about the future status of the Mater Hospital, and you responded with an interesting and useful on the provision of acute services. However, I am not sure that you answered the question.

Mr Compton:

The Mater's future is safe. Whether it will continue to provide all of the services that it currently provides is a matter of some debate. The document highlights the areas, such as emergency surgery, that we will want to discuss, not just in the Mater, but right across the Province. The Mater will be part of that discussion. We will look at accident and emergency services and at rightsizing medical beds. The maternity review is currently under way, and we have said that we

will take account of that. The question is whether the Mater is a facility that will not be exposed to change in the next few years as services change. It will change just like every other service.

The Royal will change, the City Hospital will change, the hospital in Omagh will change and the Erne Hospital will change. At present, there is no facility in Northern Ireland that I can say will remain as it is, because in changing our hospital configuration, they are all inextricably linked. We have moved past that point. There is not one single hospital in Northern Ireland at which every condition with which a patient might present could be treated.

The Chairperson:

You should be in politics. That was a very diplomatic answer; the Minister would be proud of it. I will try from a different angle: does the board have plans eventually to make the Mater Hospital what we would call a local hospital?

Mr Compton:

It will be as stated in 'Developing Better Services'; you know what that document says. That is all that I can say to you at this point. Obviously, as you know, it is not my decision exclusively. Ultimately, I envisage the decision being a ministerial one.

As such matters become public, I want to emphasise the point that there is no desire on the board's part to do anything untoward to any facility in Northern Ireland, not least the Mater Hospital. However, we need to look responsibly at what each facility will do in the future.

The Chairperson:

Do you accept that any reasonable person who reads that document will believe that, in fact, the plan is for the Mater Infirmorum Hospital to become a local hospital?

Mr Compton:

Well, people can make their own judgements as they see fit.

The Chairperson:

I had 10 years of this in Down District Council. I never could crack it.

Ms S Ramsey:

It is widely accepted that health inequalities exist in certain areas. Under the capitation formula, the amount of money that is distributed to an area depends on the age of its population. Statistics show that people who live in affluent areas live longer, receive better treatment, and so on. Claire raised a valid point on that subject. Will you seek to review the capitation formula?

Mr Compton:

The capitation formula is always under review and scrutiny. You should not assume that, simply because an area is populated by many older, affluent people who have good health status, it will receive a big pile of money, whereas other areas will not. The formula is really quite sophisticated.

Ms S Ramsey:

I know the formula, John. There is evidence that the scenario that I described does happen. A classic example is north and west Belfast versus south and east Belfast.

Mr Compton:

OK. We will agree to differ.

Ms S Ramsey:

No. We will agree that you agree with me. *[Laughter.]*

The Chairperson:

Gentlemen, that brings us to the end of what most people would consider to be a marathon session. Thank you for your time and for your responses, particularly those that answered the questions. *[Laughter.]* Undoubtedly, we will return to that issue. We must record our appreciation for those who are responsible for the document and for the huge amount of work that went into it.

Mr Compton:

Before we leave, Chairman, the Department received a series of questions from a member who is not present today. We will respond to him in writing.

The Chairperson:

Thank you.