Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Evidence Session on the Commissioning Plan 2010-11 with the Minister and Departmental Officials

3 June 2010

NORTHERN IRELAND ASSEMBLY

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COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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3 June 2010

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
Mr Jim Wells

Witnesses:

Mr Michael McGimpsey	)	Minister of Health, Social Services and Public Safety
Mr Martin Bradley	)	Department of Health, Social Services and Public Safety
Mr Sean Donaghy	)	
Mr Sean Holland	)	
Dr Michael McBride	)	
Dr Andrew McCormick	)	
Ms Diane Taylor	)	

The Chairperson (Mr Wells):

Minister, you are welcome. You have a formidable team with you today. I read Dr McBride's life story in either the 'Belfast Telegraph' or the 'News Letter' the other day, and it was extremely interesting. It was an in-depth, informative interview, and I now know more about the Chief Medical Officer (CMO). Dr McCormick and anybody who is anybody in the Department of Health, Social Services and Public Safety (DHSSPS) are also with us. We appreciate having such a high-powered team of officials in attendance. Please make some introductory remarks, after which members will ask questions.

The Minister of Health, Social Services and Public Safety (Mr McGimpsey):

I did not read Dr Mc Bride's life story in the 'Newsletter'. I am not into fiction.

[Laughter.]

The Chairperson:

I am told that he is only 47 years old.

[Laughter.]

The Minister of Health, Social Services and Public Safety:

This is the third in a series of sessions with me and my officials to provide the Committee and Assembly Members with details of the 2010-11 health budget and priorities for action. The Committee has had the opportunity to study the supporting commissioning plan of the new Health and Social Care Board (HSCB) and the new Public Health Agency (PHA). Last week, I provided details of my overall budget for 2010-11. I explained that we are dealing with a rapidly rising demand — an increase of almost 20% in two years — for health and social care. We have to make £700 million of efficiencies, some £111 million of which must be made this year alone, and our budget base is, like for like, almost £600 million behind that of England. The Executive imposed a £113 million cut on 15 April 2010, which was compounded by a further damaging financial penalty, when the Department was asked to pay £13 million towards dealing with the swine flu pandemic.

I had sought to set a budget and priorities that would provide the best possible health services for the Northern Ireland public, but that is no longer possible. The combination of all the aforementioned factors has created significant problems for my budget, which, in turn, will have a damaging impact on the delivery of health and social care. That has left me with no option but

to examine all the services that we provide to hundreds and thousands of patients and vulnerable adults and children every day.

Staff will also be affected, but I have made it clear that there will be no compulsory redundancies. I intend to keep that promise, but I must warn that any further cuts to my budget will erode such assurances.

In drawing up a budget, I have, as far as possible, made every effort to secure the existing healthcare provision. As members know, that has simply not been possible in all areas. Unfortunately, I will not be able to sustain the previous standards for waiting times, nor will I be able to introduce all the plans for new services and treatments. Even the modest investment that is being made makes it genuinely challenging to deliver yet more efficiency in the face of rising demand. That process has, to say the least, been gruelling. It is often said that there are no easy choices in health. For those who work to deliver services, the stark reality of the financial situation that we face makes that truer than ever.

Today, the Minister of Finance and Personnel said that a decision must be taken on whether the priority is the economy or health and education. Sammy, speaking at the City Hall earlier today, also said that front line services must be protected, with which no one would disagree. However, a healthy economy starts with a healthy population, and when it comes to repairing a hole in the road or a hole in a child's heart, there is no comparison.

That is why I have taken a number of weeks since the Executive's decision on the Budget to ensure that every alternative has been fully explored. Where possible, my plans have factored in the views of the British Medical Association (BMA), trade unions and officials in the Health and Social Care Board and the Public Health Agency. I welcome your comments on those plans in due course.

Since I met the Committee last week, members have heard directly from my officials on the content of the budget. As was explained last week, the process has three key stages. First, I, as Minister, resolve the priorities for, and the targets and allocations of, resources, notably deciding between existing services and new developments. Secondly, the board of the Public Health Agency proposes how services should be commissioned in the context of my priorities, directions and decisions. Thirdly, the trusts and other parts of the health and social care service make

detailed plans according to the commissioning decisions that have been approved in the commissioning plan.

Today's session moves us from the first important stage, which we covered last week, to the second; namely, the process of providing you with an opportunity to consider the joint commissioning plan prepared by the Health and Social Care Board and the Public Health Agency. I stress that many of the details of what that will mean at local level will depend on the stage of the process that is only beginning now — the detailed planning by trusts of their response to the commissioning plans.

The plan sets out how commissioners will ensure that my priorities are delivered with the available resources. This is the first time that a single, regional plan has been produced for Northern Ireland. It outlines how services will be delivered and how the health and social care needs of the population will be met. The plan includes some important initiatives. I am pleased to note, for example, the intention to take forward primary care partnerships (PCPs). Local commissioning groups will take the lead in working with GPs and other health professionals involved in primary care to ensure that the services provided are responsive to the needs of local populations. The placing of decision-making firmly in the hands of primary care professionals creates the best possible opportunity to use resources effectively for the maximum benefit of the local populations.

The next stage is that, by the end of June 2010, trusts will have prepared the final set of documents in the health and social care planning cycle. Those are the trusts' delivery plans, which will set out how each individual trust will spend the resources that have been allocated to it through the commissioning plan or obtained from other sources. Each trust's plans will have a clear focus on achieving the targets that I have set in my priorities for action. I emphasise that health and social care in Northern Ireland can do no more. England, Scotland and Wales recognise the need to protect the health budget, and the public here will expect no less.

Everyone on the Committee feels as passionately about the Health Service as I do. The founding principle of the Health Service, which is to provide everyone with cradle-to-the-grave care that is free at the point of delivery, must be upheld. I ask for your support in ensuring that the Health Service will not be subjected to further cuts, which would cause only pain and distress to patients.

The Chairperson:

For the benefit of members, the document under discussion is not the black-and-white draft copy that members received last week. We are now dealing with the draft colour version, which includes amendments that were sent to the Health and Social Care Board on Thursday 27 May 2010.

Mrs McGill:

On that point, I went through the document in detail and marked certain pages. If we knew how the old version differed from the new one, it would be helpful. I highlighted sections of the old version, and I do not have time to find out which sections have been amended.

The Chairperson:

Will one of the officials highlight what changes have been made and outline whether, for example, the tables are laid out differently?

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

There have been some textual and drafting changes and some changes to the presentation of the figures. However, nothing substantial has been changed. When answering questions, we will do our best to cross-reference the old version with the current one. I am sure that we can handle that during the discussion.

Mrs McGill:

I will refer to the information in the old version. If something to which I refer to is not contained in the new version, perhaps the officials will let me know, so that we can come back to that.

The Chairperson:

Claire, it is more likely that we will quote from information that appears on a different page in the new version. Therefore, if you explain the section to which you are referring, I think that we will be able to find the information. Given the time constraints, it is not possible to plough through both versions. I also refer members to the Committee Clerk's brief on the draft commissioning plan, which is, of course, based on the new version of the document.

Minister, do any other officials wish to say anything or may we go straight to questions?

The Minister of Health, Social Services and Public Safety:

We can move on to questions.

The Chairperson:

So much of the document is crucial that it is difficult to know where to start. However, we should start with the basic budgetary issues. Do the trusts have budgets for the current financial year, of which some 15% to 20% has already elapsed? The pie chart on page 27 shows the proportion of the cake that each trust receives. However, for the current financial year, does every trust have a table outlining exactly how much it has under each heading?

The Minister of Health, Social Services and Public Safety:

Yes, because each trust has its budget from the previous allocations. However, that budget settlement has been constrained by the cuts that have been imposed and by other factors that could not have been predicted, such as the increase in demand.

The Chairperson:

It is stated on page five that the detailed plans for delivery are not yet ready.

The Minister of Health, Social Services and Public Safety:

The delivery plans will come next. I remind the Committee that I did not know what my final budget was until the middle of April 2010. We had expected to have that information at the end of last year, which would have enabled us to go through that process. I also remind the Committee that this is the first single commissioning plan for all of Northern Ireland.

The Department of Health, Social Services and Public Safety is the only Department to achieve certain goals as part of the review of public administration. It is also the only Department that has reduced the number of quangos. As the Committee knows, we have reduced the number of trusts from 19 to six and the number of boards from four to one. Previously, each board commissioned for its area, but now the Health and Social Care Board, together with the Public Health Agency, commissions for all of Northern Ireland.

The process is that the trusts draw up, in conjunction with the HSCB, the service delivery agreements for the activities in which they will engage for the rest of the year. The local

commissioning groups, one in each trust area, feed that information into the board's plan. All the major parties here are represented on those groups. GPs and primary care lead the commissioning groups and help to determine health needs according to the budget.

The Chairperson:

What level of consultation was carried out with the trusts in developing the plan?

The Minister of Health, Social Services and Public Safety:

John Compton will give evidence to the Committee later this afternoon. As I do not want to steal his thunder, it would be better for him to talk the Committee through the consultation. In that respect, the trusts are the providers, and the Health and Social Care Board decides what needs to be provided. The process is led by primary care, informed by the local commissioning groups and determines the health needs in a particular trust area.

The Chairperson:

Where is the commissioning finance plan for 2010-11 that is mentioned on page 32?

Mr Sean Donaghy (Department of Health, Social Services and Public Safety):

The process, which the Minister outlined briefly, was that the budgets for the entire 2008-2011 period were agreed in April 2008, and funds were allocated to commissioners on that basis. The current debate is on the impact of the recent adjustment to that budget and decisions made by the Executive in April 2010. Largely, that is being addressed by the other leading plans that the Department had in place and was ready to take forward.

The board has now communicated to the trusts the detailed impact of those adjustments on the base allocations. Over the next three weeks or so, we will hear the trusts' individual responses to how they will handle that impact and meet their objectives and targets. As it stands, the draft commissioning plan seeks to guide me through how those rationalisations were arrived at. It outlines how the previous plan, which was based on the 2008 budget, is being changed and how it is proposed to take that forward in 2010-11. John Compton and Eddie Rooney will provide the Committee with more detail on that.

The Chairperson:

Given that we are one sixth of the way through the financial year and no overall financial plan is

yet in place, it will be extremely difficult for the trusts' finance officers to try to hit a moving target.

The Minister of Health, Social Services and Public Safety:

I will ask Andrew to respond to that, Jim. Given that the financial year starts on 1 April, it was highly frustrating that the Department's money was totalled in the middle of that month.

Dr McCormick:

There has been detailed dialogue with the trusts on the financial plans that they must make and the challenges that they face. As I said last week, the trusts know where they stand. The main decisions announced last week related to the details of the service developments. That is fully reflected in the draft commissioning plan. Considerable efforts have been made to keep going with as much as possible that is new in health and social care, whilst recognising that we must rein back plans and previous expectations. It is now becoming clear that those projects that are new, under implementation or being expanded will be affected.

As Sean Donaghy explained, the ongoing basic budgets for the trusts have been in place since 2008. Therefore, the trusts have been aware of the challenges that they face in delivering efficiencies. The basic financial governance exists, and we are strengthening that to make sure that everything can be delivered. The trusts know where they stand and have a firm basis on which to plan, because they have been working closely with the HSCB in particular and with the Department and the PHA to make firm and viable plans for the way forward.

Mr Gardiner:

Minister, how much do you require overall to run the Department of Health, Social Services and Public Safety? At a previous meeting, I proposed that that budget be ring-fenced. However, that has yet to happen, because no Committee member seconded my proposal.

The Minister of Health, Social Services and Public Safety:

The approach so far has been to prioritise within Departments, but we have to weigh up what each Department does against the other. No Department does anything that is unworthy, but some services are more important than others. There must, therefore, be a wider discussion on where priorities lie across all Departments.

The total revenue budget for this year is £4·3 billion, up from £4·076 billion for last year. In real terms, the uplift, excluding inflation, is 0·01%. However, there are problems. To take the Department up to the £344 million target for efficiencies will cost an additional extra £111 million. Over the past two years, we could not allow for that in the budget, because it had not happened previously. The utilities bill for water and sewerage now runs at a non-budgeted £39 million per annum. The rise in demand for elective acute services, community services and non-elective services costs approximately £150 million per annum. If you add those together, that is the extra money that we are trying to find. In addition, the Executive imposed revenue cuts of £92 million, and we must find a further £13 million, again at the behest of the Executive, to pay for swine flu. Our budget may be viewed as one particular figure, but various charges and costs significantly reduce it by approximately £600 million.

The Chairperson:

You referred to this morning's speech by the Finance Minister to the Institute of Revenues Rating and Valuation, which is an organisation that I have not come across. He said:

"These are challenging times and over the next few years we will see massive reductions in public expenditure, not seen since the 1970s."

Have you been given any indication, by the Executive or the Treasury, of what will happen with the first £6 billion of cuts, otherwise known as the Osborne cuts? Have any decisions been made, even tentatively, about how the health budget will be affected? Will it be ring-fenced, will certain services be protected, or is everything still up in the air?

The Minister of Health, Social Services and Public Safety:

I have received a paper from the Finance Minister. That paper is hot off the press and runs through the issues to discuss. It does not propose ring-fencing anything. I do not have a copy of the paper with me. I am not supposed to show it to anyone anyway, but I know that you would not tell anyone if I showed it to you. However, health is not mentioned at all.

Mr Gardiner:

We must put pressure on the Finance Minister and request that he ring-fence the health budget, because the Health Service is one of the most important services to the community.

The Chairperson:

Sam, we agreed to revisit that issue after hearing from the Health and Social Care Board and the Minister and considering our stance.

My assessment is that the Health Department will be expected to find roughly £64 million. Is that correct, or is it less?

Dr Michael McBride (Department of Health, Social Services and Public Safety):

Do you mean the consequences of the cuts on the Health Service?

The Chairperson:

We are not arguing about the figure. It could be as high as £64 million, but I was hoping that somebody would tell me that it would be lower. Is there anything built into the plan to take into account the possibility of such a figure?

The Minister of Health, Social Services and Public Safety:

Not a thing. George Osborne's £6·2 billion of cuts exclude the health budget, which has been ring-fenced.

The Chairperson:

The health budget has been ring-fenced only in GB; it has not been ring-fenced here.

The Minister of Health, Social Services and Public Safety:

That is devolution for you. Edinburgh has decided to ring-fence its health budget, as have Cardiff and London. As George Osborne has put that proposition forward, the cuts should exclude any cuts to the health budget. Therefore, it is doubly unfair that the Health Department here must help to pay for the cuts.

Members should be aware that the budget for policing and justice is ring-fenced. Patients are as important as prisoners. You mentioned a figure of £54 million or £64 million. Pro rata, we receive less than 40% of the Northern Ireland Budget, yet we are consistently being told that we receive closer to 50% of the total. I am not clear on how the sums are calculated or what the result of that calculation will be. I do not even have an Executive proposal in front of me to consider, although that is with them as we speak.

It seems that, following the action by the other Governments in the UK, the way forward is to ring-fence the health budget, not least because we already spend £600 million less than England on health. This year, England's Department of Health's budgetary increase in real terms was 1·7%, compared with 0·1% here. Last year, our budgetary increase was 1·2%, whereas the Department of Health's was 4·3%. Therefore, the Department of Health is ahead of us in budgetary terms, and its budget has been ring-fenced and will increase, as will those in Scotland and Wales.

Mr McCallister:

Has your percentage of the overall Budget has fallen since the devolution of policing and justice, when the £800 million package came into play?

The Minister of Health, Social Services and Public Safety:

Yes, that is correct.

Mr McCallister:

Are you saying that you will have to make the same proportion of cuts as you did before policing and justice powers were devolved?

The Minister of Health, Social Services and Public Safety:

Not only must I make cuts that are proportionate to the health budget's allocation of the overall Budget, it looks as though I will pay for a proportion of every other Department's cuts. I should say that the Health Service incurs those costs, not me.

We should follow the approach of the rest of the UK, because the cuts from George Osborne in London specifically exclude health. The cuts are managed in such a way that health services should not be reduced.

Mr McCallister:

However, you have no control over what the Minister of Finance and Personnel does, apart from collective lobbying on the part of the Committee.

The Minister of Health, Social Services and Public Safety:

That is correct. My party colleague and I voted against the last budget cuts, which cut the health resource budget by £92 million and also cut the capital budget.

The Chairperson:

Before we move on to local issues, members will ask about the general overview of funding. You propose to replace the women's and children's hospital by using the top three floors of —

The Minister of Health, Social Services and Public Safety:

That is for the women's hospital only; it is not for the children's hospital. The original proposal was that the two hospitals be built simultaneously. The funds are not there and will not be for many years. By splitting the project, it can be taken one bite at a time. The first part was the women's hospital at a cost of £150 million. No matter how I calculated the capital profile — even before the cuts — the project was still seven to eight years away. Therefore, I examined the current capital spend to determine what we could use for the current build.

The Chairperson:

Implicit in that announcement was that you had some indication of the capital that would be available for the incoming year. We are still a bit in the dark about many projects, the commencement of which are keenly awaited by communities. When will we receive clarity on the bricks and mortar as opposed to the revenue?

The Minister of Health, Social Services and Public Safety:

Mr Donaghy will speak about that. Each capital cut does not kill a project, but it pushes it further out. The other problem that we had was that we had allowed for about £90 million through the disposal of land, but that was simply not achievable. We received money for the first three years, but I am trying to plan for the future. As there was no possibility of having the money for the women's hospital within the next five years, I re-examined what was being done with the top three floors of the eight-storey critical care building. I thought that there was an option to use that for the women's hospital, which would mean that a brand new women's hospital could be delivered within a couple of years. That remains an option, but consultation is required, and I must talk to the clinicians, and so forth. I am trying to use a wee bit of lateral thinking to get to where we want to be.

Mr Donaghy:

I will fill in some of the detail behind the Minister's remarks. It is possible to make a firm decision about the Royal Victoria Hospital (RVH) phase 2B because it is already a committed scheme, and decisions on its funding have already been taken. It is not dependent on short-term decisions on the capital budget for this year. Rather, it is a matter of changing the application of capital funds that have already been committed.

In the context of the cuts that were notified to the Health Department in mid-April, £21·5 million came out of this year's capital budget. Therefore, we know what the 2010-11 capital budget is, subject to there being no further impact from the cuts that were announced by George Osborne and depending on how the Executive choose to read that across into health and social care. We simply do not yet know whether that will affect capital at the margins.

The more material uncertainty is what the capital outlook will be in 2011-12, 2012-13, and so forth. As the Committee knows, most of the major schemes, of which RVH phase 2B is a good example, take years to plan and construct. That is why the Minister mentioned that, in the context of the reduction in this year's budget, we have had to put back the start dates of a series of schemes. It would be irresponsible of the Department to commission a major scheme that runs into millions of pounds without being confident that it would have the funding in three years' time to complete it. Until the budget outlook for capital is sufficiently settled to enable us to plan those schemes across many years, the uncertainty about when some of those schemes can start will remain.

The Chairperson:

Tommy, is your question on capital expenditure?

Mr Gallagher:

Yes, it is. It is clear to all of us that a decision to stop capital spend and concentrate on services is starting to kick in. The Minister mentioned the decision on the women's hospital, as distinct from the women and children's facility, which some people expected and quite a few argue that we need. We all understand the dilemma to some extent, and, of course, something is better than nothing. However, has the Department analysed the situation fully?

Forgive the crude analogy, but I was a member of the Committee for Regional Development

for a while. The Department for Regional Development (DRD) spent money not on new roads but on patching up roads. It ended up as a disaster, because no improvements were made to major infrastructure. Other parts then got into a very poor state over time because everything was being spread too thinly.

The new children's facility will not happen. Have you analysed the likely long-term damage to the hospital in Omagh, many health centres, and so on, that will result from not being able to proceed with some of the capital expenditure?

The Minister of Health, Social Services and Public Safety:

The children's hospital will proceed, but the timescale is far away at the minute. If I can find a cleverer way, I will go for it. Similarly, Omagh hospital is very much part of the plans. As far as capital expenditure is concerned, you talked about maintenance and compared us with DRD. I can assure you that we spend our money much better and much more efficiently than DRD does.

Mr Gallagher:

I could not comment.

The Minister of Health, Social Services and Public Safety:

We spend some £100 million on maintaining the estate and ensuring that repairs, such as fixing leaks, are carried out at hospitals when required. There is constant wear and tear of those buildings, given their massive footfall. There is a constant need for repair, and, if those repairs are not done when they are needed, the estate simply deteriorates. The bill for the maintenance of a proper fit estate that is particularly compliant with health and safety regulations is some £100 million.

Before I became involved, it was estimated that £7·8 billion would be needed to repair and renew the health and social care estate, because very little money had been spent on it. Of our £7·8 million bid, we received less than half, and that is spread over 10 years. The figure for the first three years was £230 million, and that allowed us to go ahead with certain schemes. The hospital in Downpatrick is now finished, and we are proceeding with the hospital in Enniskillen. That is a private finance initiative (PFI) with a large £100 million bullet payment to reduce the unitary cost.

All the schemes are on site. Work on the critical care building at the RVH is on site. Building work had reached the third or fourth floor, so now was the time to act. It would have been too late to intervene if we had not done something now. I decided to examine whether we could adapt the top three floors to give us a new maternity hospital as planned. A new children's hospital is a burning priority. The front of the Royal Belfast Hospital for Sick Children is brand new, but the rest of it is in very poor shape because it dates from the 1930s. That is how we plan our capital expenditure.

The original allocation was not enough. The amount that we are receiving is still being reduced, but, at the same time, some tasks simply have to be done. For example, the Ulster Hospital ward block was built in the 1950s, and it has concrete cancer. It is a 600-bed acute hospital, and, basically, it cannot be repaired. If that hospital were to be lost and the system took such a hit, it could not cope. Therefore, the Ulster Hospital is an absolute priority. Those are the type of choices that we are making. The tower block at Belfast City Hospital was built in the 1970s, and hardly any money has been spent on it since. There are also needs at Daisy Hill Hospital and Altnagelvin Area |Hospital. There is need everywhere. I am trying to spread the money as best I can and get the best result and response possible.

Mrs McGill:

At one stage, there was talk about a newbuild for the learning disability community in Strabane. Has that disappeared completely? I ask that in the context of prioritising the most vulnerable people in society. The project may not be far down the road, but I understood that something would happen. I spoke to the director recently, and he told me that there did not seem to be any signs of anything happening. However, there is a need for such a facility.

The Minister of Health, Social Services and Public Safety:

There is need all over, Claire.

Mrs McGill:

I understand that.

The Minister of Health, Social Services and Public Safety:

I am not familiar with the Strabane proposal. That does not mean to say that it is not live, but simply that I cannot think of it. I receive so much information. I will chase that for you.

The Chairperson:

Will you drop us a note to bring us up to date on that?

The Minister of Health, Social Services and Public Safety:

I will do that.

Dr Deeny:

I am committed to giving our people the best standard of healthcare possible. Your arguments for ring-fencing money are becoming stronger. I do not want any of us who are involved in healthcare to see the health of patients suffering as a result of all this. That is the biggest incentive of all. If money were ring-fenced, what would you do that you could not do if it were not ring-fenced? I am talking about primary care centres of the future, and Sean Donaghy spoke about the committed schemes that people are looking out for. If the money were ring-fenced and you were happy with that, what would you and your Department commit to?

The Minister of Health, Social Services and Public Safety:

In respect of services, there are a number of things that we are doing, and there are a number of things that we cannot do. I will ask Michael McBride to run through those for us because he advises me on a number of issues.

We had to make cuts to the service. As far as I was concerned, the approach was to keep the show on the road and preserve what we have, which meant stretching bit and losing a bit on waiting times. It also meant asking more on drugs efficiencies — a huge ask — and not proceeding with all the innovations that we wanted to proceed with. Some three quarters of that work will not be done, but at least we can ensure that we are still doing what we are doing, which gives us a chance to meet increases in demand.

Dr Deeny:

Primary care is a big player here. If money were not ring-fenced for that, do you envisage a delay in the move from looking after people in secondary care and hospitals to community care, which is happening across the NHS? That is a big worry in the community.

The Minister of Health, Social Services and Public Safety:

If money is not ring-fenced, the question is whether we stand still or stand still according to inflation. Standing still, without a real terms hold, means reduction. We are at a tipping point, and, in places, the situation is quite fragile.

We maintained our front-line services because the number of staff has not changed. A certain amount of staff can do a certain amount of work, and once that work increases, the number of staff should also increase to have any chance of managing the situation. Cuts will bring staff levels down, which could leave a gap between the number of staff and the volume of work that there is no chance of meeting.

Dr McBride:

I will pick up on that specific point. I can say, without equivocation, that any further impacts on the health spend will significantly constrain the necessary changes in the delivery of health and social care.

The Chairperson:

If the £64 million is transferred to the Health Service budget, can you give us some examples where you feel that action would have to be taken with regard to capital or budget in order to take effect?

Dr McBride:

I am happy to do that. The Minister sought to emphasise the positive actions that we would take in service development as well as what we achieved and what we will invest in next year. We highlighted the approach to maintaining existing services, as the Minister explained, and sought to constrain, phase and delay new investments in services.

Many of the new projects that Kieran mentioned are about getting upstream. Those projects are about ensuring that people, particularly older people, can live independently in their homes; offering supported living to people in their homes; reducing dependence on the residential sector; reducing admissions into hospital; and facilitating earlier discharge into the community.

At our last meeting, we mentioned investment in mental health. That is important work, but the reduced spend in, for instance, respite packages for people with learning, physical or sensory

disabilities means that we cannot invest as much as we would have liked to in important projects that would have begun to transform radically how we deliver health and social care. Those are still included in the Minister's priorities for action. Issues such as primary care partnerships, the reorganisation of acute hospital services and living at home still remain priorities in the overarching themes of the draft commissioning plan that Eddie Rooney and John Compton will speak about.

I will concentrate on the reduction in planned service developments. The new money that we were to invest next year has been reduced from £76 million to approximately £18 million. I am not a director of finance, but if we have to find another £60 million, that will leave health and social care facing some unpalatable decisions.

We are investing an additional £4·75 million in stroke services next year. That is half the money that we had intended to invest. The consequences of that are that we will still be able to enhance stroke services and thrombolysis for the 4,000 people who have strokes in Northern Ireland, and we will still begin to make an impact on the target of a 10% reduction in the number of people who die from strokes in Northern Ireland. However, if we have to find further cuts, we will not be in a position to deliver and extend such services next year and still be able to balance the books. Those are the level of decisions that we are talking about.

We were planning to invest in an additional 2,000 dementia packages next year. As a result of the reductions in our budget, we will invest in only 1,200, which is a shortfall of 800. Clearly, if there are further reductions, we will have to revisit that figure.

There are profound decisions with profound consequences. The Minister's point is that all our work across government and all Departments is important. The impact of further reductions to the health budget on society and on the population of Northern Ireland will be very profound indeed.

The Minister of Health, Social Services and Public Safety:

I will ask Sean Holland to talk about social services and children's services. A key area is vulnerable adults and children. Sean will demonstrate how the Department strives to preserve the work in those areas. We will provide the protections that we have to, but the situation is tight.

Mr Sean Holland (Department of Health, Social Services and Public Safety):
We invested significantly in children's services during the previous CSR period. For the most part, with the pain that we face, we consolidated the gains in children's services. Significantly, in addition to the CSR funding, we also mainstreamed some £7 million of children and young people's funding package initiatives at the beginning of the CSR period, and we held on to all of those.

Those investments have been about improving the service across three primary areas: early intervention and prevention; strengthening front-line child protection services; and trying to improve the outcomes for children and young people whom the state has received into care. All three of those areas are vital, and it would be intolerable if further cuts were to leave the directors in the trusts who are responsible for child protection services in the position of being unable to respond to concerns that they hear about a child now. Front-line child protection services are needed to do that.

It is most desirable that early intervention and prevention be carried out. Our previous track record on children who are in care is poor, and we are trying to improve it. However, we must maintain a front-line child protection service to respond to a member of the public, a GP or another health professional who calls to say that they are concerned about a child today. Further cuts would mean that we would have to consider reducing the early intervention services and the parenting support services that we established in the past few years, which help children stay with their families.

We would have to consider reducing family support packages, which help families with children who are on the edge of care and who are perhaps on the child protection register. Those packages help to support families to keep children at home in the community.

Sadly, we would probably have to cut back on innovative services that we introduced over the past three years, which have been about trying to improve outcomes for looked-after children in the system. Unfortunately, looked-after children do not do particularly well with educational attainment. I do not have the exact figures, but I will provide them in writing. However, between 10% and 12% of looked-after children received five GCSEs between A* and grade C. In a relatively short time, our investment in that aspect of how we look after those children has pushed the figure to between 17% and 18%. We did that by providing extra tuition and additional classes

for children, and we allowed children and young people who are in care to stay with foster carers up until the age of 21 if they are in education or training.

Unfortunately, we will probably have to revisit and retract those measures so that we can maintain a front-line child protection service. That is anti-strategic, and it is not what we want to do. It does not look to the years ahead, it is not preventative, and it is not upstream. However, it would be intolerable to leave directors, who have a statutory duty to respond to children who are reported to them as being at risk, not being able to provide that service. Kieran, you asked about where we would make cuts. We would have to cut those worthwhile areas to maintain a front-line child protection service.

Ms S Ramsey:

Minister, you are welcome. It appears that you have come in with a football team. I know that the World Cup is starting soon, and it is interesting to see the number of officials with you.

I commend you on the movement on the review of public administration. It is not fully recognised that the streamlining of Health Service structures can now begin. For some reason, Minister, we got off on the wrong footing. The Committee and I want to work with you, and I have no problem in saying that health has been underfunded for years. However, I also believe that millions of pounds have been wasted in the health sector, and I know that you are of the same opinion. That is a key issue about efficiency savings.

I would appreciate the Committee receiving feedback from the meetings that the Minister held with stakeholders: the unions, the community sector and the meeting with NICVA last night. I am unsure whether that meeting should have happened before or after this Committee meeting. I am concerned that we got off to a bad start, and we do not want other problems to go into the mix to add to that issue. I am not saying that that was done deliberately, but the Committee needs to be given its place. I agree that we need the involvement of the community and the unions.

The review of the Investing for Health strategy is vital. We must have the involvement of all Ministers. I do not want to get into the argument that it is easier to take money from Roads Service or the Department of Culture, Arts and Leisure or whomever to invest for health. If we do not invest in our people, the economy will not go anywhere. Executive involvement in that review is crucial.

When we met last week, I raised initiatives about newbuilds with the Minister. Have you or your officials looked to other Departments — for example, the Department for Employment and Learning or the Department of Enterprise, Trade and Investment? There is a crisis in the construction industry and also with young apprenticeships. Those Departments could step up to the mark and give some funding towards newbuilds. We need to think outside the box. We must be the masters of our own destiny.

Have you asked the Executive for a single issue meeting about health? It is important that the Executive as a whole get their heads around the issue.

Consultants' and GPs' pay is also a bone of contention. Is there any move towards regaining control of that into local hands for negotiation so that it is not out of our control and decided in London?

My next question may not go down well. The vice chancellor of the Ulster Unionist —

Mr Gardiner:

That is a good party. *[Laughter.]*

Ms S Ramsey:

The vice chancellor of the University of Ulster took a 5% pay cut last week. I commend him for that. I have asked whether that money will go back into the Department or the university. Is there any possibility that senior officials, doctors or consultants will take a pay cut or freeze? I hope that I do not end up in hospital this weekend. *[Laughter.]*

I am waiting for more information on the RVH so I do not want to make a judgement on the phase 2B scheme.

The Minister of Health, Social Services and Public Safety:

I will ask Diane to respond on the unions. However, I strongly believe that this is a team game, and everyone is in it together. It is important that the staff side is kept up to speed. I would not want the situation to get out of sync by their receiving information before the Committee does. I take the point about the Committee having its place, and I also feel strongly about that. That is

why the draft commissioning plan will not be fixed until the Committee has had a chance to discuss it.

I have not had a single issue meeting with the Executive, and I do not think that there has ever been one. However, we are about to discuss finances so I will make that proposal and let you know what happens.

I was in the building industry all my life. Certain types of building are labour-intensive and others are not. Building motorways is not so labour-intensive; that entails large pieces of machinery, and so on. However, building houses and intricate buildings is labour-intensive. The critical care unit at the RVH, for example, needs many folk on the job, so there is a big economic driver with capital. The joy of it is that most of the materials used are home-grown — concrete, gravel, and so on. That is an important issue.

The sharing of buildings with other Departments has not yet started. The only one that I am aware of is on the Shore Road in Belfast, and we share it with the libraries and Belfast City Hall.

Ms S Ramsey:

I am not talking about sharing buildings. I am saying that there is a crisis in the construction industry, so if, for example, the DHSSPS needed to build tomorrow, would there not be an onus on the Department of Enterprise, Trade and Investment and even the Department for Employment and Learning to provide some of the money? That would help to put people through apprenticeship schemes, help the construction industry and mean that the funding for such projects would not all come from the health budget.

The Minister of Health, Social Services and Public Safety:

I agree with that, but the problem is in persuading other Ministers. We have to think laterally and creatively outside the box.

The contract for consultants and GPs is national. Diane deals with human resources, so she can discuss GPs, consultants and the unions. Michael can discuss Investing for Health, which is his baby. A review of that strategy is under way.

Ms Diane Taylor (Department of Health, Social Services and Public Safety):

The Minister is committed to partnership working with the trade unions. We briefed the trade unions last week, and another meeting has been arranged for next week. They work at regional and local level with all the health and social care organisations, so dialogue is continuing with the trade unions. Martin may want to comment on the nursing union.

We engaged with the independent Doctors' and Dentists' Review Body (DDRB) to examine economic factors and produce recommendations on GP and consultant contracts. Those recommendations are put to the Secretary of State for Health and two local Ministers in the devolved Administrations. We are not sure if that process will continue with the new Conservative Government. We do not know whether they will want to engage with pay review bodies and whether we will continue to be part of that process. There is a four-country human resources meeting arranged for July in which we are taking part. We will discuss future pay issues at that meeting, and I am happy to update the Committee afterwards. We have no plans to leave any national agreement, and we will consult with the other countries on the future.

The Chairperson:

That is an interesting point. If we want to, and felt that we could, retain GPs and consultants in Northern Ireland on a lower pay scale, could we voluntarily leave the negotiations and strike our own rates?

Ms Taylor:

I am not sure that the Minister would be prepared to take that step and come out of a national agreement with the trade unions and the British Medical Association (BMA).

The Chairperson:

Could we do that legally? It might not be politically acceptable, but could we decide that we simply could not afford to pay the current salaries?

Ms Taylor:

Thought would have to be given to the implications of stepping outside of the process, because GPs and consultants here could be paid a different rate to their counterparts in the rest of the UK. The implications of that could include the loss of highly talented individuals, who have been very good at running our Health Service, to better paid jobs.

The Minister of Health, Social Services and Public Safety:

We could hold an entire meeting on the issue. We have national pay deals. By and large, the people who work in the Health Service are not highly paid; they are at the lower end of the scale, albeit of a national pay deal. The folks at the top who get the big wages have talents and skills that could readily be transferred to any of the other home countries, the Irish Republic or the US.

Routinely, representatives from hospitals in America visit Northern Ireland on headhunting expeditions. We have a very good medical and nursing workforce and health workforce that is locally trained and loyal to our local Health Service. Therefore, I would be concerned by any suggestions that would end up disadvantaging those people because of their loyalty. There will be discussions at a national level, anyway, and we need to see what emerges from them.

Ms S Ramsey:

I want to provide the flip side of that argument. There is a national pay agreement, but when there was an increase in pay for nurses a number of years ago, nurses here had to fight long and hard to be included. Nurses in England got an increase in pay, but nurses here did not.

Ms Taylor:

Was that not when the pay award was to be staged, and our Minister decided that he would pay it in full at the beginning of the year.

Ms S Ramsey:

No; the situation that I am talking about was a number of years ago.

Ms Taylor:

The pay freeze for GPs and consultants is, effectively, the recommendation of the DDRB this year. It felt that senior doctors should demonstrate leadership in that area and accept a pay freeze.

Ms S Ramsey:

Does that also include bonuses — or whatever they are called?

Ms Taylor:

Clinical excellence awards are separate and not part of that. They are part of the terms and

conditions and consultants are eligible to apply for them. They are not dealt with in the pay award in the same way.

Ms S Ramsey:

Is that negotiated in London?

Ms Taylor:

It is negotiated centrally.

Ms S Ramsey:

Somebody can receive a clinical excellence award of £76,000 because it is negotiated —

Ms Taylor:

No; that is not the way in which those clinical excellence schemes operate. Consultants in Northern Ireland put themselves forward for awards, they are considered by an independent committee in Northern Ireland, and awards are made to the best people.

Ms S Ramsey:

Can we have a copy of whom they were paid out to over the past two or three years?

Ms Taylor:

Absolutely. The information is on our website.

The Minister of Health, Social Services and Public Safety:

That would be helpful, as would information about why they were paid out. They are paid out for innovation, creativity and advances in particular fields of health and social care. I am going to the Nurse of the Year awards tonight, and I assume that you are also going. You will hear about our nursing workforce's achievements over the past year. Some of the advances are very exciting and save the Health Service money.

Our doctors, GPs and consultants are in a similar situation. Some of them have been innovative and inventive. For example, in the cancer centre in Belfast City Hospital, there are individuals who have worked in the United States and have returned with ideas, whereby we end up with developments.

The Chairperson:

We do not mind a plaque being given to a consultant with such achievements. However, in the present economic climate, £11 million is given as recognition while other organisations give £50 — not £74,000 — and people have the glow of knowing that they have been recognised by their superiors. It is the scale of the awards that are given to folk who are already, in most people's opinion, extremely well paid that gets under the public's skin.

The Minister of Health, Social Services and Public Safety:

We will develop the issue further with the Committee because it is not as simple as that. Staff could have the glow of an award over here, but they could have the glow of a financial award by working elsewhere. We want to hold on to those people in Northern Ireland, which is another key issue.

Mr Gallagher:

You mentioned that this is the first year that Northern Ireland has had a regional plan. The chief executive of the Health and Social Care Board is a witness later today, and we will learn something about the draft commissioning plan.

Everyone is trying to deal with dental care issues. Are you satisfied that dental provision is satisfactory across Northern Ireland, or are there still gaps in the availability of NHS dentists? Are you happy that, under the new arrangements, what was started will continue and be seen through?

We are being told that there will be more direct payments as a way to look after people in their homes because they will spend less time in hospital. However, direct payments are a problem because many people do not know how to handle them. Perhaps they cannot handle them because of their age or other circumstances. Has the Department given any thought to doing more about that given that you want to encourage more direct payments to deliver better facilities to help people? It is not there at the moment. People are told to avail themselves of direct payments. In order to encourage them, some thought should be given to a facility that will help families who may be interested but who do not have the capacity to handle direct payments.

The Minister of Health, Social Services and Public Safety:

Some 50,000 patients outside the NHS cannot access NHS dentistry. Therefore, a tendering provision was issued for that work. I am satisfied that the tender will deal with that, and, if it does not, we will re-examine the situation to ensure that nobody is disenfranchised and that everyone is treated equally.

The commissioners will consider whether the trusts are promoting direct payments and whether they need to deliver them in a better way. Sean Donaghy will talk about direct payments, which may not work for some folks but that work very well for others.

Mr Donaghy:

There are examples of direct payment schemes working well. However, it is acknowledged that the associated bureaucracy can be daunting. The In Control pilot scheme started in the Southern Health and Social Care Trust area last year. In that pilot, most of the bureaucracy is managed on behalf of the individual, but the scheme still gives people control to redirect their care away from standard day care to, for example, innovative use of leisure or recreational facilities. Adjusting to that type of scheme poses problems for the Health Service. However, we are examining that pilot, learning lessons where we can and trying to reduce the associated overheads. It is clear that allowing people a say in how their care is delivered improves their experience of care and helps them to live independently for longer.

We have made progress. However, more needs to be done to reduce the overheads that are associated with bureaucracy. There are some positive examples of that happening, particularly in the Southern Trust area, where a system called Vela microboards brings individuals together to support those with high levels of dependency and need. However, we need to be able to roll those examples out to people with ordinary needs, so that they are not deterred by the bureaucracy that is associated with direct payments. As the Minister said, the trusts are being asked to examine ways to motivate people and to make it easier for a larger take-up of direct payments in the year ahead.

Dr Deeny:

Last week, Minister, I told your senior team that the fact that there are three West Tyrone MLAs on the Committee for Health, Social Services and Public Safety speaks for itself. All members are committed to health. However, there are still major concerns in West Tyrone not only among

the public but among professionals. We have lost acute services in Omagh, a consultant neurologist has been lost through whom we had access to state-of-the-art tele-neurology, and a consultant dermatologist has been lost through whom we had access to tele-determatology. Just yesterday, I learned that we have also lost one of our X-ray consultants, with the result that a musculoskeletal ultrasound scan sent back to me because that service is no longer available. Many people are worried that the top-quality staff to whom you referred are being lost from our area.

I commend you for doing things, as you said, in a more intelligent and cost-effective way and for your commitment to the women's centre. Although it is not a centre for women and children, you are thinking about the needs of patients, and that is good.

A couple of weeks ago, the Committee held a meeting in my native town of Downpatrick, and members were very impressed by the new hospital there. Satisfaction was written across all our faces. Will you consider the provision of that type of hospital in Omagh, which would demonstrate that you are going to deliver on your commitment? Such a hospital would cost one third of the price, save the Department £120 million and meet the needs of patients. It is a win-win situation. Clinicians say that that type of facility, albeit smaller than the one that was proposed, would meet the needs of patients and save the Health Service money. I am convinced that that view is shared by clinicians and the public alike.

I have read GP magazines in different countries, and I am pleased that the current Secretary for Health, Mr Lansley, has so far said the right thing about not closing local hospitals or local health facilities without hearing the views of local clinicians. It is important to take that on board. Do you see that as a solution to the problem that three members of the Committee are trying to address and that a different approach will save your Department money?

The Minister of Health, Social Services and Public Safety:
You talked about the loss of a number of senior consultant staff. It is important to preserve the workforce and its skills. That is a constant concern for me.

The local hospital network has a strong future. Tyrone County Hospital is now a local hospital, and I understand that it is busier than ever. That model is working. We have an acute hospital network and a local hospital network. A local hospital will carry out a great deal of day-

case surgery, for example, and meet around 70% of the hospital needs of the local population. A liaison committee that comprises members of the Western Health and Social Care Trust and Omagh District Council is evolving a model for Omagh. As you are aware, the proposal is to have a hospital, a health and care centre and a mental-health acute hospital. The liaison committee is moving forward with the proposals for those three elements.

Downpatrick has a hospital and a mental-health facility, but it is different in that it does not have a health and care centre. The Downpatrick model is a reasonable one for us to follow for Omagh. If I had the money, Kieran, I would build the new facility tomorrow. Capital is vital, but there are also revenue costs in running a hospital. Therefore, there are revenue consequences, which is why the budget is crucial. I can assure you that a hospital for Omagh is still very much part of my plans, but every cut pushes issues back a wee bit.

The Chairperson:

Minister, you will find that West Tyrone MLAs hunt in packs. Thomas Buchanan is next.

Mr Buchanan:

I apologise that I missed the early part of the meeting. There is a question mark over the newbuild in Omagh because of the constraints on the capital budget. That has put the plans back somewhat, and we are not sure how long it will be before those come to fruition. Will the constraints affect the current delivery of services at Tyrone County Hospital, or will those services be built up to the level of the proposals for the new hospital?

Some £5 million was spent on enabling works on the site of the newbuild last year. The liaison committee informed us of a proposal to spend another £7 million on enabling works this year. Will those works go ahead, or will they also be put on hold because of the constraints on capital spend?

You said that, to run hospitals, revenue is needed as well as capital. However, is the revenue not already in place? The transfer will be only from Tyrone County Hospital to the new hospital. The revenue to run Tyrone County Hospital already exists, albeit revenue that may need to be increased somewhat. Therefore, is the revenue for a new hospital not more or less already in place?

Constituents whom I have dealt with have found direct payments very beneficial.

The Minister of Health, Social Services and Public Safety:
Thank you for that.

Building hospitals today is not the same as previously because they are now, across the board, much more complex, intricate and expensive to run. Therefore, there is a revenue consequence for the newbuild in Omagh. However, that is helped by the fact that revenue is already flowing through the current hospital site.

A range of services is planned for the new hospital. They are very much part of a local hospital profile, such as care of the elderly, day surgery, emergency services, cardiology, renal, obstetrics and gynaecology consultancies, imaging, and so on. Kieran, you probably know the details better than me because you are on the liaison committee. I do not know why you are asking me; I should be asking you. Those facilities amount to more than is in the current hospital, as I understand it, so there will be an increase in activity. However, Tyrone County Hospital is busier than ever and is a strong performer. There is a need, which is addressed in my capital spend and capital profile. I am looking to do that, but the capital profile is vital. The Department of Finance and Personnel's proposals about how we consider capital are very frightening.

Mr Buchanan:
If the project is delayed, will it affect the services that are currently being delivered at Tyrone County Hospital?

The Minister of Health, Social Services and Public Safety:
Not that I am aware of.

Mr Buchanan:
What about the £7 million enabling works?

The Minister of Health, Social Services and Public Safety:
I do not know the details of that contract. I know that there has been investment in the site, which demonstrates that it is a serious proposal.

The Chairperson:

We would be happy enough to take a written reply on Sue Ramsey's question about Investing for Health. We now come to the last of the West Tyrone members, Claire McGill.

Mrs McGill:

Minister, you mentioned the Omagh hospital liaison committee. Some of us met another group from the west recently at an informal lunch meeting. Dr Kate Law was present, as was Father Kevin Mullan and Mr David McKee. During those discussions, if I remember correctly, Dr Law set aside the newbuild to some extent. She talked specifically about enhanced services in the existing building. As you rightly said, Omagh District Council is part of the liaison committee. Does anybody have any comments about that approach? Dr Law referred to the fact that Tyrone County Hospital has been refurbished, so she seemed to suggest that it is important that services be maintained and enhanced. You mentioned that already. Perhaps that could be the case in the existing building.

Before we hear details from John Compton and the commissioners, is it still your and your Department's commitment to finance appropriately, in so far as is possible, the most vulnerable people in our society and those, for example, with a learning disability, mental-health issues and those who require social services? Is that definitely still the priority, and, in your view, does the funding match that stated priority? Is that the case, or is that the attempt that is being made? I want to hear that because it will be important when we discuss the details with the commissioners.

The Minister of Health, Social Services and Public Safety:

Sean Holland covered some of those issues. Mental health, learning disability and children's services are priorities and should be ring-fenced. That means that the existing money that we are spending will stay there. That is where we are currently. Indeed, we managed some extra investment in those areas, but that could be threatened by further cuts.

Mrs McGill:

Is there enough, even at this stage —

The Minister of Health, Social Services and Public Safety:

No. Listen —

Mrs McGill:

What about the money? Who decides? I was looking at some of the figures, and it did not seem to be that much. Does the commissioner decide? Does the commissioning board decide? Do the local commissioners decide, or does the trust? Who finally decides the pocket of money that goes to those most vulnerable groups?

The Minister of Health, Social Services and Public Safety:

Ultimately, we do. The decisions on how much money is spent and in what areas are made through the Executive, the Assembly and the Committee. However, as I explained, we are a long way short of having enough money. Therefore, it is a matter of trying to keep the show on the road. We are aware that we deliver health and social care according to budgets rather than need. I am conscious of the need for health and social care in many other areas. However, I have been making that argument for the past three and a half years and will probably continue to do so. Health and social care, in common with education, is so important that it should be an overriding principle.

I have nothing to add to what I said to Tom and Kieran about the Omagh hospital: it remains a priority. The existing Tyrone County Hospital is busy, and we must ensure that its buildings meet health and safety standards. Therefore, in the meantime, investments will be made, and refurbishments will be carried out to make sure that the service that we provide to patients is safe and secure.

Mr Easton:

Thank you, Minister. I apologise for being late.

Page 16 of the revised draft commissioning plan states:

"Within the HSC today we commit 4.1% of the commissioning resource to management costs."

Do all trusts meet the 4·1% target to which the plan commits them? How will you make sure that that happens? Are you considering any other ways to reduce bureaucracy, in particular for nurses, who now spend much of their time on paperwork?

My next question is on funding for health groups, such as FASA in my North Down constituency, which is still waiting to hear about funding. FASA provides a valuable service that

assists the Health Service considerably, and, were its funding to end, that would be unfortunate. Will you commit today to funding such groups?

The Minister of Health, Social Services and Public Safety:

When FASA was opening its facility on the Shankill, I talked to staff about the need in North Down, and, from that discussion, came the Bangor drop-in centre. I have said publicly that I consider there to be a genuine need for that facility. FASA is coming to the end of its current round of funding. However, there is money for which FASA can apply, and, as I understand it, its application is going ahead. I have given assurances that FASA, which comes under Michael's public health remit, will receive funding, because it, along with a number of other groups, plays a vital role. Such groups reach certain areas of the community that the statutory sector finds more difficult to reach.

We have gone through the RPA and reduced our trust management costs. Instead of having 19 chief executives in the trusts, there are six, with a corresponding reduction in the number of directors that go with those posts. Similarly, the number of boards has been reduced from four to one. Diane will detail other changes in the trusts for the Committee.

I will ask Martin to outline the nursing situation. It is a matter of concern that nurses, particularly ward sisters, have to deal with so much bureaucracy that they are pinned to desks rather than allowed to work the wards. I will say more about that in due course.

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

Over the years, the pressure of keeping up with paperwork has increased for the nursing workforce. Some of that paperwork is clinically, rather than administratively, orientated. Early warning scores, for example, are increasingly being used in the acute sector and, therefore, must be recorded regularly. On the administrative side, the Minister has, in the past year, allocated £2 million to support ward sisters who work in hard-pressed areas to ensure that they receive extra support in carrying out the administrative and management tasks in which they have to engage.

A ward sister runs a 28- to- 36-bed enterprise 24/7. People come and go, and ward sisters face the pressures of patient admissions and discharges and ensuring that everyone receives sufficient nutrition, hydration, and so forth. The ward is a mix between a hospital facility and a hotel. Inevitably, that combination brings with it a wide range of tasks and administration.

The Minister has allocated £2 million to help ward sisters in hard-pressed areas. To try to cut out bureaucracy, he also allocated £2,000 to each ward sister to facilitate the easier completion of minor capital works. Previously, a ward sister who needed a replacement light bulb had to get a chit or receipt signed off by four or five people. Now, the ward sisters have the money to get the work done within a reasonable time. That is a good example of the way forward and of the kind of issue that is being addressed.

Mr Easton:

Will the trusts be held to the 4·1% target in the draft commissioning plan?

The Minister of Health, Social Services and Public Safety:

Scrutiny panels are in place to ensure that the workforces reach that anticipated point. As far as management is concerned, I think that the figure is already below 4%, but I am not sure.

Ms Taylor:

Over the past few years, management costs have appeared inflated because of the inclusion of the Agenda for Change arrears, but we are almost at the end of that process. Over 99% of staff have been paid their arrears. Under the RPA, there were 188 senior executives in the service: the chief executives and the tier below, which meant that 188 staff occupied the top two tiers in the organisation. That number of senior executives is now 80, which is a huge reduction. In administration, clerical and managerial grades, we have removed just over 1,200 posts from the system. Our target is to continue that workforce reduction until March 2011, and the reduction in management costs should also continue throughout the year.

The Chairperson:

Some trusts find it much more difficult to hit the 4·1% target than others. What is the mechanism for ensuring that no trust will transgress?

The Minister of Health, Social Services and Public Safety:

There are scrutiny panels, the Health and Social Care Board commissions its plans from the trusts, and HR also plays a role. We will ensure that the efficiency board — I cannot recall its exact name —

Dr McCormick:

The two boards will chair a programme board to ensure the delivery of the efficiency savings, including our commitments under the RPA. A shared service phase, which is in progress, will mean streamlining the way in which support services are managed. There is some way to go, but the key point is that each trust is required to meet and deliver specific targets as part of the RPA. The trusts are being held to those targets as part of the wider programme management of securing efficiencies.

The Chairperson:

I want to flag up an issue that we will raise with Mr Compton later. A storm is brewing in the Limavady area about out-of-hours cover and the significant cuts that will be imposed from 1 July 2010. You will find that quite a few of the MLAs from that area will be beating down your door. Last night, a public meeting on the issue attracted a high attendance.

The Minister of Health, Social Services and Public Safety:

The cuts are not major. The trust was rearranging the service, and I am satisfied with what they have done. Virtually no one was calling the service between midnight and 6.00 am, and, therefore, cover was rearranged to ensure the availability of GPs during busy times.

Dr McBride:

That mirrors the point that Kieran made. It is a matter of aligning the health and social care workforce to the demand. An analysis that was carried out by the board showed that, on average, the five GPs in that area saw about four patients between midnight and 8.30 am. That was not, by any stretch of the imagination, an effective use of their time. There has been no reduction in the hours of cover or in the number of access points at which patients can be seen and assessed. GPs have simply reorganised their rota to ensure that three of them cover the area at any one time and that three additional GPs are in reserve and can be called in should there be any additional demand.

It is a restructuring of health and social care to make the most efficient and effective use of resources. It is the sort of reconfiguration that we should support and welcome. Importantly, there will be no diminution of the service that is provided to patients.

The Chairperson:

Claire attended last night's meeting and may want to give you a flavour of what the community feels.

Mrs McGill:

An important point that came out of last night's meeting was that nurses will require training for the new service, which it is proposed will be in place on 1 July 2010. However, at a briefing of Limavady Borough Council the previous night, we heard from the training provider that those nurses could not possibly be fully trained until September 2010. Chair, your party colleague George Robinson and several other elected representatives from that area asked whether consideration could be given to postponing the implementation of the proposal until September 2010, by which time the nurses who are crucial to its effectiveness could be trained. I would like clarification: is it the case that nurses could not be fully trained until September? Will a postponement of the proposal's implementation at least be considered?

Dr McBride:

Unfortunately, I was not at the meeting, Claire, and, therefore, I cannot comment on the specific details of the time required to train staff. Nurses are expert members of any clinical team. They triage patients daily in A&E departments and in health and social care generally. They provide nurse-led services in A&E departments across the length and breadth of Northern Ireland, and they are skilled professionals in their own right.

I do not know the specific details of the plans or the length of time required to train nurses in Limavady. I hope that the board and the agency will be able to answer your specific question. If not, I will be happy to provide specific details of the length of training. We propose no diminution of the service that is provided to patients. Indeed, the improvement of outcomes for, and experiences of, patients is at the heart of the Minister's priorities for action and of the board and agency's commissioning plan.

Mrs McGill:

John Compton will have the detail that I require, but thank you for that response. The matter affects a large geographical area in the north-west, which stretches from Derry to Strabane to Limavady and beyond.

Mr Gallagher:

I take some comfort from the Chief Medical Officer's response. As I mentioned last week, there is a concern about a small number of people using an expensive out-of-hours facility that costs more than £20 million each year. As fewer staff will be involved under the new initiative, will money be saved? Many people in rural areas, instead of using the out-of-hours service, go straight to A&E, which puts more pressure on that service. There are a couple of dimensions to the situation on which I would like more information.

The announcement about the Western Trust was made only a few months ago without any serious level of consultation, certainly in rural areas. I note the emergence of concerns in the Limavady area, and, I suspect that further concerns will emerge when something similar happens in places such as Fermanagh.

The Minister of Health, Social Services and Public Safety:

I am happy to provide written details to Claire and Tommy. As I understand it, there will be six doctors: three on duty and three on standby. It is a question not of saving money but of matching the capacity to demand.

Mr Buchanan:

Are GPs and other health professionals in the area content to buy into that arrangement?

The Minister of Health, Social Services and Public Safety:

I do not have that specific information, but I will provide that to the Committee.

The Chairperson:

Dr Devlin addressed the meeting in question, and he was most unhappy. However, we will take that matter up with the board in the later session.

Minister, an hour and a half has elapsed, and we have given the new draft commissioning plan a fair degree of scrutiny. I thank you and your team for the information that you provided and for the way in which you dealt with the questions. We appreciate the fact that you have a strong team. It contains a formidable mix of youth, good looks and experience — I will not say who has which attribute. We will come back to you in writing on some of the issues raised.

The Minister of Health, Social Services and Public Safety:

Thank you very much.