Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Impact of Budgetary Cuts and the Health and Social Care Review

28 September 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Ms Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Michaela Boyle
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Sam Gardiner
Ms Pam Lewis
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

Mr Kevin McAdam	)	Northern Ireland Committee, Irish Congress of Trade Unions
Mr Kevin McCabe	)	Northern Ireland Public Service Alliance
Mr Jonathan Swallow	)	UNISON

The Chairperson:

I welcome Kevin McAdam from the health services committee of the Irish Congress of Trade Unions, Kevin McCabe from Northern Ireland Public Service Alliance (NIPSA) and Jonathan Swallow from UNISON.

Lads, tá fáilte romhaibh. You are all very welcome, and it is good to have you here. I will ask you to do a five-minute presentation. Time is tight; I am sure that you have already been advised

of that. We want to get through the business in the time allocated. I suspect that what you say will provoke a few questions. We must be as strict as we can with the time.

Have you decided who will go first? Good man, Jonathan. It is great to see someone volunteer.

Mr Jonathan Swallow (UNISON):

We thought we had 10 minutes, Chair, but if it is five minutes, it will be five minutes.

First, we need to draw to the Committee's attention the continuing uncertainty about the health budget for this financial year and next. It is full of non-recurrent funding, and no one knows whether that will be funded next year. The system is crashing through that. A previous draft of the commissioning plan showed a 4% annual cost pressure for the next four years, but that failed to take account of current levels of inflation. Our analysis, pending someone telling us the real picture, is that there is a 6% cost pressure in health for the next four years, which is double the cost pressure of the previous three. That creates an ongoing crisis of funding.

Secondly, we have analysed the delivery plans produced in draft by the six trusts at this stage of the process. I emphasise to the Committee that a system in which there is a commissioning plan, five local commissioning plans, six trust delivery plans, a performance and efficiency delivery unit (PEDU) review and now a ministerial review seems excessively complicated to resolve what the health needs are and what can be delivered in this financial year.

In our analysis of the delivery plan, the predictions made by the Department of Health, Social Services and Public Safety (DHSSPS) last December and January have come home to roost, namely restricted access to community care; critical care only; and major delays in assessment and discharge. We have the analysis of the plan by the Belfast Health and Social Care Trust, which seeks to remove over 100 beds in the next 12 months, with about 150 jobs going in consequence. There is continuing pressure around the blocking of hospital beds — it is not a phrase that I like — and the failure to meet discharge targets.

When we examine how trusts are reporting their performance against waiting time targets, we see a move from a creaking system last year to a collapsing system this year. In our press releases, we detailed the many and varied failures to meet those targets, which patients reasonably believed were a guarantee of service within a reasonable and effective time.

We are very concerned at the position on medication. One trust has £500,000 to fund multiple sclerosis drugs and a total need of £2·3 million. Again and again, we hear trusts saying, as does the commissioning plan, that some drugs prescribed and approved by the National Institute of Clinical Excellence (NICE) are unavailable for financial reasons.

There have been substantial job losses to date, and further substantial losses are signalled. We are now seeing, as symptoms of the crisis, unplanned closures, such as that of Belfast City Hospital's A&E department, and a reduction in hours at Lagan Valley Hospital's A&E department. The commissioning plan does not fulfil its legal obligation to take account of the capitation formula and how money is distributed, particularly to areas of deprivation. The plan signals closures as an early part of a four-year strategy. However, it does not explain the details of those closures. Other colleagues will talk about issues such as re-ablement and medication. The Appleby report states that mental health is currently underfunded by 44%. The health board's commissioning plan now accepts that services to children are underfunded by 30% in this society — the plan has no section on children's services. Therefore, a crisis currently exists, and it needs to be addressed through funding and investment.

The Chairperson:

Thanks, Jonathan. Thank you for sticking to your allotted time. I am very impressed. Which Kevin will speak next?

Mr Kevin McAdam (Northern Ireland Committee, Irish Congress of Trade Unions):

I want to focus from the perspective of the Congress of Trade Unions on our concerns about the John Compton review that is now in progress. First, we believe that a review of the health service that will last less than 90 days cannot properly analyse the problems that exist or, indeed, come up with a rationale on how to go forward. We want to express our concern that the Compton review will be nothing more than a rehash and cherry-pick of other existing reports, such as the McKinsey report. We are concerned about the effect that that will have on the service. We want to reference the fact that the health service has been reviewed almost to death over the past number of years by different means through the review of public administration, which has not yet embedded throughout all parts of the service. We feel that it is important to raise, from a trade union perspective, the effect of that on service delivery in so far as there is continuous change and no bedding in of any system. The review ought to take an extensive look at how a

better health service can be developed, starting with investment. That ought to be the review's goal. I will stop there.

Mr Kevin McCabe (Northern Ireland Public Service Alliance):

I am Kevin McCabe from the Northern Ireland Public Service Alliance (NIPSA), and I am one of the delegation's joint secretaries. My colleagues have covered the main issue, which is finance. Our difficulty is the lack of clarity. We had wanted to comment on the draft commissioning plan that the board had produced, but the board says that the entire plan is subject to ministerial influence and change and that any input that we could have at this stage would be nominal. The review must be viewed against the other key drivers, such as the McKinsey report; the current departmental review; the performance and efficiency delivery unit (PEDU) review; and Appleby reports. When aligned with the draft commissioning plan, are these value-for-money audits? One in particular that concerns our members in social services is the current value-for-money audit that will look at the £200 million currently spent on domiciliary care. We believe that that area has been targeted with a view to alleviating the budget deficit. Indeed, there is absolutely no doubt about that; even the review's terms of reference support that view. That leads us into a circular argument about whether services should be ring-fenced. There is a strong and compelling argument based on previous reports, not least that of Lord Laming, that children's services should be ring-fenced. However, that brings us to the question of whether you should rob Peter to pay Paul; whether education and health should enjoy better allocations from the block grant than other areas. Our union does not espouse that view, because it just creates problems down the line.

Jonathan touched on the vicious circle that exists. Despite the good work done by the Bamford review, resources are simply not being made available for mental health provision. Children's services in Northern Ireland receive 30% less funding than those in England, Scotland and Wales. Those are real problems. We are trying to deal with the commissioning plan; we are saying that we could talk to you about how certain services are being delivered better. However, that is set within the context of the limited funding available, or, indeed, the severe lack of funding.

That sums up our perspective on the funding deficit and the impact on health and social care.

The Chairperson:

OK. Thanks to all three of you. It is interesting that you used the phrase "robbing Peter to pay Paul". The health budget is massive; it is 40% of the block grant. I was in the previous Executive, and I know what it takes to run a Department and how top-slicing affected my Department considerably. At times, I felt that the Department of Health, Social Services and Public Safety had to find better ways of using that 40% to ensure that service delivery and outcomes were better and to resource those areas not receiving their full allocation. That feeling has been compounded since coming to this Committee, because it seems that acute services constitute the black hole into which the money goes and that other services are the poor relations as a result. I do not think that Peter is being robbed to pay Paul, but if the Minister took that line to ensure better outcomes for the money spent, I would support him.

I appreciate the succinctness of your three presentations. It was good to see a lot of hands going up as soon as you started to talk, meaning that there are many questions to be asked from around the table. It was interesting, and worrying, that you made it clear that you were not needed when it came to having an input into the draft commissioning plan. In July, when we discussed the matter with the Minister and John Compton, we hinted that the Compton review might not take 90 days; for all we know, it could be written already. I doubt that any of us will be able to influence it. We have been invited to meet the Compton review team earlier than we had planned, but I am sceptical about the amount of influence that we can have. Nevertheless, it is interesting to hear a trade union perspective. I have pressed and continue to press the Minister — I have to keep separating my role as Chairperson from my personal views — on the need to work with the trade union sector. You are the people on the ground, and he needs to work with you and take your views on board.

Mr McCarthy:

Thank you very much for your presentations. I cannot disagree with anything that any of you said. I cannot understand why you cannot get the message across to the Health Minister and the Department that we all want a first-class health service delivered free at the point of need. Yesterday, the Minister made a statement about the health and social care review. I questioned him on two issues, and I would like to hear what you have to say. He said:

"It is not just about cost cutting". — *[Official Report, Vol 66, No 6, p322]*

He also said that the review "is not about saving money". Do you agree with that?

Mr McAdam:

Having had brief discussions with John Compton, I do not think that that would be his view. He was quite clear that money would have to be saved as an outcome of that exercise, and that is where the review is going.

Mr Swallow:

Our fundamental issue with the review is that it does not take need as its starting point; it takes where we are with the budget. It is something of a Titanic deckchair issue — simply shuffling about. Secondly, the review is being carried out within the current budget envelope. Need is demonstrated by the deficits in mental health, children's services and acute services, as acknowledged by Appleby. A review must start from the point of need rather than from the current budgetary position. Not to start with need is to let people down. In one delivery plan, I read that trusts are admitting children with severe mental health psychosis to adult mental health wards. The target, however, is only to reduce that practice, not to end it. That must be our starting point in an honest discussion of those issues.

Mr McCarthy:

I absolutely agree. We had a discussion about mental health issues with the Department before you came in, and those same issues were brought up. In my opinion, the way things are going and will probably continue to go, is scandalous. I do not know whether you have seen the Belfast Trust's delivery plan, but many important elements of that, including cancer targets, are unachievable. Why is that?

Mr Swallow:

The five delivery plans show a consistent collapse of service delivery and a failure to meet waiting targets. Those are issues that matter to patients. That cuts across service after service. In some cases, one almost senses that the trusts have given up. The Western Trust states in its delivery plan that, to meet the nine-week target for seeing an allied health professional, it needs eight more occupational therapists, 11 more physiotherapists, and for no one to take maternity leave, holidays or resign for the next two years. Its current performance is between 26 and 30 weeks, not nine weeks. If we were to profile the health service on waiting times and ask what the target is and what is contained in the trusts' delivery plans, we would see a situation that has moved from creaking last year to near collapse this year.

Mr McCabe:

The review is about the Minister's vision and strategy: improving public health, the prevention of illness and the improving of outcomes for patients and clients. Who would disagree with that? However, he goes on to state:

"The issue of overall funding levels available to meet the needs of Health and Social Care now and in the years ahead is also outside the scope of this Review as that is a matter for the Executive collectively drawing on the advice of DFP. The current PEDU review of the scope to make savings in the Health and Social Care sector is separate from the HSC Review and the development of an implementation plan to deliver savings will continue in parallel with this Review."

I have a problem with the interrelationship between the reviews. There is a lack of clarity and a sense of being given the runaround. I do not think that the two can be divorced. The departmental review cannot operate without at least acknowledging the £40 million deficit this year and the £200 million deficit up to 2015. You could have all the visions, strategies and outcomes that people would love to see, but they would belie the financial reality. It is then said that the Executive will have to deal with the question of overall funding and that the PEDU review will look at internal savings. The latter, however, will not meet the scope of the savings presented by the problems. There is some obfuscation about where savings might be made or who might —

Mr McCarthy:

I used the term "waffle" yesterday, and I did not get a very good response. The Minister did not answer my question.

Mr McCabe:

Yes, waffle.

Mr Wells:

Do you accept that special treatment was given to the Department of Health, Social Services and Public Safety in the Budget, in the sense that other Departments had to make very difficult decisions on efficiencies? At least the health aspect of health and social care was ring-fenced and protected and given a 1·9% real increase in resources. Everyone believes that we are in a difficult position. I hope that the unions realise that at least some of what they said has been taken on board. In terribly difficult financial circumstances, health was given a priority that inflicted a lot of pain on the Department of Agriculture and Rural Development (DARD), the Department for Employment and Learning (DEL) and other Departments that had to take a hit to facilitate it.

Secondly, do you accept the Finance Minister's commitment that should PEDU, which is working in the Department at the moment, decide that economic efficiencies cannot be applied to the budget allocated to health, top-slicing will be applied in order to protect the essential services that you outlined? Those are two major steps forward in the protection of the Health Department budget. Other Departments received no such protection of their budgets.

Mr McAdam:

You are right about the 1·9% increase in the budget, but, in the current climate, that represents a net cut. The RPA is at 5%, so we face a considerable cut in the health service budget. Chair, you referred to the fact that the health service budget accounts for 40% of the block grant. If that is not enough to provide the healthcare needed, we must look at it again. One of the difficulties with the health service is that there are and will be increasing demands as technology and drugs advance. We can save more lives, but we need the funding to do so. The Government need to face up to the fact that the health service has an expanding budget that needs to be met. Some will say that it is a continuous drain, but it is not. That is why an increase of 1·9% will not save the health service from the catastrophe that is around the corner.

The Chairperson:

When Bairbre de Brún was Minister, the budget was £2 billion; it is now £4 billion. In those 10-odd years, need has not doubled, and the quality of service certainly has not doubled. That £4 billion must be better managed. We still await the decision on consultants' bonuses, on which £11 million a year was happily being spent, and we asked the Minister about that yesterday. That is the kind of expenditure that we believe is inappropriate and unaffordable in the current climate.

Mr McAdam:

May I briefly respond? When Bairbre de Brún was the Health Minister, there were a lot of "derelict", if I may use that word, hospitals around. The country and the health service were in an awful state because of the continual underfunding by your predecessors from across the water. So the reason for that contrast is that considerable money needed to be spent on services to bring them closer to what we would say is an acceptable standard. We should stand up and take credit where credit is due, because there have been many good changes to hospitals and services, but that is not enough.

Mr Swallow:

The debate up to now has been theoretical, whereby everybody takes a position. However, the fact is that the trusts' delivery plans show the gap in service delivery. Service deficits also exist in children's and mental health services. That is our starting point. We do not preclude solutions, but we start from the point of need. We are alerting the Committee to the day-to-day crisis rather than to the three-year crisis ahead. Along with the Northern Trust, we analysed the number of jobs delivering front line care that has been lost in the past nine months as a result of existing budgetary constraints; that number is between 200 and 300. We suggest that the solution to that crisis is funding and investment. We need the current review and PEDU, into which trade unions have had no input whatsoever, to identify the real extent of that gap and to give that information to the Executive for consideration.

Mr Wells:

You keep talking about jobs lost. In fact, there have been no redundancies among the 70,000-odd people who provide care in social services. I accept that 2,000 jobs have been lost as a result of natural wastage. What you fail to mention is that, if a business case is made for the replacement of jobs assessed as essential, they are replaced. For instance, 50 nursing posts were replaced because they were deemed essential.

I understand that the Minister said in a recent press release that his door was open. He welcomes input from the unions. A monthly meeting is held at Castle Buildings to allow all the unions involved in the health service to have their say, and the Minister attends those meetings when he can. He is saying that, given the present circumstances, his door is always open to all who want to come and make those very points. I am slightly disappointed, therefore, that, as I understand it, there has been only one such meeting since the recess.

Mr Swallow:

My union met the Minister last week, and he subsequently tweeted that he found the meeting useful. So there is no walking away from open doors on our part. I would be happy to supply the Committee with detailed evidence, taken from departmental figures, of the reduction in support service establishments in all five trusts over the past four years. Services are being constrained because jobs are not being replaced, and, for example, there is now a situation at Antrim Area Hospital where cross-infection targets cannot be met and bed capacity is run at 95%. That is not a viable way of delivering acute hospital care.

Mr Wells:

If that is the case, the Northern Trust should put a business case to the Health and Social Care Board, stating that those are essential posts and that it cannot do without them. If the board deems that to be the case, the posts will be replaced. There is no question of any situation at Antrim Area Hospital in which essential posts, which obviously require replacements, are allowed to remain frozen. The non- replacement of natural wastage applies only to posts that the trusts believe they can get by without, albeit with difficulty. I do not say that that is easy, but the trusts believe that they just have to get on with it and try their best. However, where it is essential to replace posts, given the present job market, there is absolutely no difficulty in getting staff in most fields.

Mr McAdam:

As Jonathan pointed out, vacancy controls over the past four or five years have been running at 7%. I will give you a stark figure to demonstrate how that works out. The pharmacy department in the Mater Hospital has 50% vacancy control in place. That means that half the number of staff who were there two years ago now do all of that work. The situation is becoming unsustainable. That is a real example of how vacancy control affects service delivery. Had the vacancy controls been lifted, many more people could have been employed by the health service.

Mr Swallow:

I gather that members have in front of them the Belfast Trust's delivery plan. That clearly indicates a 50% increase in vacancy control in this financial year, simply to get to the point where they hope for bridging finance from the Department.

Mr McCabe:

Jim, you asked certain questions in response to some of the points that I made. If you say that the increase in health funding meant that other Departments had to suffer, I have to accept that. However, it all goes back to what I believe is systemic failure. Whether the problem lies with the Barnett formula, or whether the block grant is not enough, we have to find things as we find them. The previous Minister, his officials and, indeed, members of the previous Health Committee concurred with the view that the level of funding afforded to the health service merely allowed it to stand still. Things have moved on, but in a worse direction, with closures at the Belfast City Hospital and Lagan Valley Hospital because they are unable to provide services.

That is the start of a deteriorating and spiralling drop in service.

We received an undertaking from the previous Minister that there would be no compulsory redundancies. When we asked the new Minister the same question, he said that that was not necessarily his thinking. He said that compulsory redundancies were less likely than more likely — read into that whatever you want. He also said that he would not necessarily go back to the Minister of Finance and Personnel with a begging bowl. That makes us believe that we are in for unpleasant times ahead. He also said that there may be thousands of job losses but not necessarily thousands of compulsory redundancies. That is from a staff point of view, but we are here to present a wider argument that is not solely about the self-interest of the staff.

Those are the arguments that are being made, and I do not think that they stack up. One Minister considered that he did not have enough money; another says that he wants outcomes and that he has a vision and a strategy. However, there is still a major deficit.

The Chairperson:

The Committee's view is that the Minister could have made a bid in the most recent monitoring round. We have asked to see the bids for the October monitoring round, and we will take a view then. We were broadly supportive of the Minister's seeking more money from the Minister of Finance and Personnel. We are not saying to him that he has enough money and should get on with it. Rather, we asked him to tell us what he planned to bid for so that we could consider it. If we support it, we will say so. It is not about trying to make him manage on his current budget.

Mr Gardiner:

Jonathan, Jim mentioned a meeting with the Minister.

Mr Swallow:

Yes. I was not present, but a meeting with my colleagues took place.

Mr Gardiner:

Was that the first meeting with the Minister?

Mr Swallow:

Yes. The meeting focused on the partnership initiatives that my union has taken to improve

service delivery and to involve workers more in service delivery and release their ideas. We briefed the Minister on that issue and on a major project in west Belfast/greater Shankill that generates employment by training people on a pre-employment basis. I gather that there was, inevitably, a wider discussion on the future direction of the budget.

Mr Gardiner:

How long ago was that meeting held?

Mr Swallow:

Last week.

Mr Gardiner:

If I were in your position, I would have wanted that meeting to be upfront.

Mr Swallow:

It was an upfront meeting. As I said, the Minister is now on Twitter, and he tweeted that the meeting with our union was useful.

Mr Gardiner:

OK. Kevin, you raised the issue of ring-fencing health. Many members of the current Committee did not sit on the previous one, so I cannot point any fingers. On three occasions, the Committee rejected my proposal to ring-fence the health budget. Only in the latter days of that Committee did I receive the support of a few members, because those normally opposed were not present on that day. I fully support ring-fencing the health budget, because health is the wealth of our nation. We need it to be protected, so I support you.

Mr Dunne:

We all recognise and would like to put on record the valuable contribution that health workers make to the provision of healthcare. As union representatives, how do you propose to contribute to the Compton review? It is a great opportunity for you to have an input, take some ownership and influence change. How do you intend to do that?

Mr McAdam:

Initially, we met John Compton at the partnership forum, where he outlined what he intended to

do. As of this afternoon, we have set up dates for the collective trade union group to meet him on a workshop basis. Each individual trade union has sought a meeting with John Compton to represent its workforce's views to him. We will certainly engage with the review. Does that mean that we can be convinced of what will happen? As Michelle pointed out, she does not know whether the review has already been written. That might be the case, but we have to engage, and we will. Throughout the changes in the health service, the trade unions have always recognised that change is part of what it does. We engaged, and our members managed that change, sometimes better than others.

Mr Dunne:

You are the people who know what is happening on the ground. You know the needs and what is required, so it is important that you have a major input. At the end of the day, you have to recognise that there have to be efficiencies and change. Those will be driven right from the top, so it is important that people such as you are involved. You need to recognise that and not simply go to meetings and oppose everything. Where you see that there can be efficiencies and real change, you have to bring forward positive proposals. Everyone will benefit.

Mr Swallow:

We will meet at least two visiting members of the review team. Chris Ham is widely recognised as the leader of the King's Fund, and Ian Rutter is from my neck of the woods in Yorkshire. We will start by pointing out to them just how constrained the review's brief is. We will suggest to the entire team that the issues that we raised with you today about need and delivering need are fundamental to the review and that simply carrying out that review within the current budgetary envelope is not appropriate. We will then seek to build a relationship with members of the team, teach them and hope to communicate to them all our insights into the current crisis in the health service.

My union previously gave evidence to the Committee about the absolute and objective need to move from treatment to prevention. We have put that on record in our evidence. We will not have a disagreement with the team about that, but we think that, to do that, you need a system that functions rather better than the one we have at the moment, despite the best efforts of all our members — and thank you for acknowledging that.

The Chairperson:

Gordon, you talked about efficiencies. The UNISON paper mentions a proposal to withdraw a number of treatments, and, Jonathan, you made the point that many of the procedures affect the health of women and older people. The proposal would have a disproportionate impact on women; they are particularly targeted. I have read through the list, and I find it very worrying that some of the procedures on it might be withdrawn. We asked the Department for further information, and we got a paper that said that various procedures were under review. Tonsillectomy was one that jumped out at me. However, a lot of the procedures on the list — female genital prolapse, dilation and curettage, hysterectomy – affect women's health. In the past, we have seen that women's health has not been as big a priority as other areas. We are at the bottom of the pile, along with children and older people.

The paper is interesting, and when we get a chance to digest its content, there will possibly be a need for further discussions with the unions. I certainly think that we would be keen to keep the unions on side and to ensure that we have ongoing discussions and that you know where we are so that you can send us any information that would be useful to us. We would very much welcome that.

Mr Swallow:

The list that you are referring to is the list produced in a recommendation for Northern Ireland in the McKinsey report. Subsequently, we have discovered that it is a direct cog from a rationing initiative from the Croydon Primary Care Trust — it is almost word for word. Of course, the per capita funding in Croydon is substantially greater than that in Northern Ireland.

The Chairperson:

That rings a bell. We challenged the Minister on that, and we said that we need to develop healthcare for the needs of our population and keep Croydon out of it. We talked about that with the Minister and John Compton at the July meeting, but we have not heard anything more from them.

Ms Boyle:

Thank you for your presentation. We have just been given your paper, so we will take it away and digest it. I am looking at the impact of savings plans on patients in the Western Health and Social Care Trust area, which is in my area. The paper states:

"The Trust confirms that 10 older people who have had inpatient treatment for mental health cannot be discharged because of the cash limits on residential and domiciliary care."

That is very alarming. We have just had a session with officials from the Department at which we discussed how severely underfunded the mental health budget is. The issue goes further than that. I know a number of those 10 people, and the fact is that, in my area, the number might be more than 10, and that is because of the complex relationship between mental health and other ailments that those people have. I can think of one young male in his early 50s who is one of those 10 people.

As the Chairperson said, it is important that we keep you on board and, vice versa, that you keep us informed of the knowledge that you have. It is very helpful that you have come here today.

Mr Swallow:

Everything in our analysis of the five trust delivery plans is taken directly from the plans. The trusts have behaved with integrity in accurately stating what they can and cannot do within their current budgets. It is not the usual budget game where everyone hypes it up to try to get a bit more. I can spot that from a long way off. I am very experienced on both sides of the table in that regard. So, I was struck by the integrity of the trust delivery plans and the trusts' absolute commitment to saying what the situation is with the targets they are supposed to achieve. In some cases they have told us things that have made us all very uncomfortable. However, if we were to take those five plans in total and map a number of the key targets that are not being achieved, we would have a profile of a health service in very serious difficulty.

Ms P Bradley:

Thank you, gentlemen. I am sorry that I missed the beginning of your presentation. I do not know whether I should declare an interest; I am still a paid-up member of UNISON. I am delighted that you are here to represent the staff. I worked in social services in Antrim Area Hospital for many years, and I fully understand the staffing pressures; people are not replaced and temporary staff are put in place. I do not want to say too much, but I am delighted that we have someone here to represent the staff, who are so demoralised and under pressure. They need to have a voice in the Committee.

Mr Brady:

Thanks for the presentation. I want to follow on from what Michaela said about the 10 older people. Surely it is more expensive to keep them in hospital? We had 'People First' in 1990, and we had care in the community and all those wonderful documents that paid lip service to what should be done. It is estimated that by 2020 our older population will have doubled. If the provision is not there now, how will it ever catch up in 10 or 11 years? Nothing is going to improve unless it happens now.

We spoke earlier about two reports that the last Committee had from two independent evaluators, and both of them said that, in a health service the size of the one we have in the North, without cuts or anything, we could have efficiency savings of between 8% and 10%. That is quite a lot of money, if we take into account the overall size of the budget. Nothing seems to have been impacted by that. It seems to me that they painted a very gloomy picture, and rightly so, because nothing has improved as far as I can see.

I have had experience of an elderly parent receiving domiciliary care, and he had 15 minutes immediately taken off him because a relative was in the house. The person who was visiting does not even live in Newry, but, because they were making a cup of tea, the social worker came in and said that they were taking 15 minutes off him, and I got a phone call the next day. That is the kind of thing that is happening. That is the reality, and it is people on the ground who are being affected.

Yesterday, I went out in Armagh to deliver meals on wheels to elderly people in their 80s. The person delivering those meals might be the only person the elderly person sees all day. In fact, that person monitors their condition; if they open the fridge and the dinner from the day before is there, it flags up that there is a problem. The Southern Health and Social Care Trust is now asking people to pay for those meals. If they cannot afford them, they do without. That is the reality. I agree that it is a daily issue; people are suffering daily. It is not long term; it is happening on a daily basis, and it is getting worse. I welcome the input of the unions, because your voice needs to be heard and need to be much stronger.

Mr Swallow:

One of the hidden tragedies at the moment is that domiciliary care is increasingly being restricted to those with the most critical need. That does not take away the issue of those who are perhaps

classed as having lower levels of need but who, as you say, live in isolation. The isolation factor is not being addressed.

Mr Brady:

The people who really need it are the ones who are the most isolated and the most vulnerable; the ones who do not have a voice. They are the ones who are being picked on.

Mr McCarthy:

Those people then need a GP or need to go to A&E, where they take up hospital beds and all the rest of it.

Mr McAdam:

It would be remiss of us not to raise the issue of the A&Es in Lagan Valley Hospital and the City Hospital. That is one issue that we raised with the Minister at our first meeting. We told him clearly that, if he is going to do what happened in Whiteabbey or Magherafelt, there ought to be engagement with the community and the trade unions, and it should be done in a planned way. The plan to change A&E services in Belfast exists, but it has an investment attached to it and a plan that will take us, in a year and a half to two years, into a new trauma centre. We welcome that and think that is right. I say to our members and the public that, if they want the best service in Belfast, they should leave from the Lisburn Road and go over. I think that you will find that everybody will.

Like everyone else, we found out from the press that they were closing the hospitals. The argument that they use of there being a lack of consultants and junior doctors has been out there for a number of years. You do not run short of doctors if you have a workforce plan, which should ensure that all of that happens. It is fair to say that it is a contrived situation. Everybody wants to reduce A&E services, and we accept that, by and large, Northern Ireland has more A&Es than elsewhere. I am not proposing that mine should get closed or that everybody will do that. We are saying that there will be, and should be, a rationalisation but that it ought to be done by engagement, not by announcing that an A&E will close next week or next month — and when I say next month, I mean October. We do not know what sort of winter we are going to have or whether or not we will be able to cope. It is important to put that on record.

Mr Swallow:

The minutes of the last meeting but one of the Health and Social Care Board specifically mention an initiative being developed to avoid A&E admissions for people with chest pains or bleeding in pregnancy. Those of us who read that minute are asking whose initiative that was and where it came from, because that is not the way to manage the A&E crisis.

The Chairperson:

To be fair, if I were going to hospital with bleeding in pregnancy, I would not want to be sitting in A&E. I would go straight to the obstetrics and gynaecology unit in the maternity unit to ensure that I was dealt with properly. I do accept that there is a tendency now for people to go to A&E when they could possibly go down a different pathway, such as going to their GP or using the out-of-hours service. I am not saying that that is the cause of the entire crisis, but we do not want anybody to be in A&E when they should not be there. A&E is for accident and emergencies. It is for people who cannot wait until 9.00 am the next morning for medical treatment. We need better service provision for people who turn up at A&E, and we need to stop people from going to A&E if they do not need to be there. We must not put pressure on already-stretched staff and resources, as that leads to trolley waits and so on, which are extremely unfortunate and very traumatising, not only for the patient but for their families, who are trying to get their loved one a level of care that they feel they are not getting.

Lads, this is the beginning of an engagement as opposed to the end of one. We will want to keep in touch with you. This has been a very useful session, and I look forward to reading through the presentation that you have given us today. We look forward to seeing you or others from your organisations again. Thanks a million for taking the time to come up today. Go raibh míle maith agat.

Mr McCabe:

Chair, we are happy to share information. However, if your role is to keep the Minister in check and the Minister's role is to keep the providers of the health service in check, what is developing in the A&E at the City Hospital in particular beggars belief. If it is not about money — the trust directors have told us that it is not about money — and if it is not about moving people for the sake of moving them or cutting services, which, again, you have to accept at face value, they are saying that it is because we cannot get the level of staff and that, therefore, it is a matter of patient safety. However, that certainly raises the question of competence. As Kevin said, it is about

having a strategic workforce plan because you know that departures are imminent and that posts need to be filled. They are saying that they have been all around the world looking for senior medical people to fill those vacancies and that they are planning for a temporary closure but that, if qualified staff become available, they will act on that. It simply creates suspicion and mistrust about the whole thing. Where are those 50,000 people going to go from 1 November? The situation will simply compound matters.

There is an issue of checks and balances and accountability as regards allowing a situation like that to get to the point where a planned temporary closure is being proposed. A barrister phoned me the other day to ask whether we can judicially review the decision. His mother had just died in the City Hospital's A&E unit. I said, "Look, from what you know and what they have told us, there does not seem to be the information." He asked if we could get the information through a freedom of information request. There is that level of mistrust and concern about the whole issue. I would rather have proper engagement and consultation so that we know what is happening rather than second-guessing.

The Chairperson:

I do not disagree with you about proper engagement. However, in the interests of fairness, I will say that when the Minister came to our July meeting and told us what was happening and that there was to be a temporary closure of the A&E, my words at the time were that it was "eminently sensible".

I come from Tyrone. I know the difficulties that there are in accessing A&E services. It is inconceivable to me that there are three A&E departments within five minutes of one another. Yes, we need management and consultation and, yes, we need to have a plan, but I do not necessarily think that having three A&Es in close proximity is good for any of us. If the situation is not working at the minute in Belfast, that is one thing. However, if we are rationalising or closing A&Es and we do not look at the three in Belfast, one on top of the other, they are going to start looking at rural hospitals. We have to ensure that everybody has access to quality medical care within that 60 minutes — the golden hour — at the very least. I make no apology for coming at this from the view that some of my constituents will be very disadvantaged if there is further rationalisation outside Belfast. The process may have been flawed, but I cannot disagree with the decision to conglomerate the three units into two.

Mr McCabe:

With respect, if that were the proposition, you could deal with it in those terms. However, you have to push them all the time for information. You have to go and ask for the business case to see what is causing the crisis. Only after pushing them into public meetings and making them come out with their reasons were we told that it is to do with patient safety and that there is a danger that the unit will be closed down because of a recent audit. Again, people will speculate and ask whether that would have happened if the previous Minister were still in charge of health: would the A&E in the City Hospital in his constituency have been closed? However, we have to deal with those wider community concerns with the staff on the ground who are affected by the proposals.

The Chairperson:

We are certainly not here to defend the Minister; we are here to scrutinise the work of the Department and the Minister. However, in the interests of fairness, I must say that the Lagan Valley Hospital is in this Minister's constituency, and he has scaled down the hours there.

Mr McCabe:

I appreciate that, and different arguments prevail. We are certainly more than willing to engage and share information with the Committee. However, it is frustrating having to find out the actual facts on the ground, and the A&E issue is a case in point.

The Chairperson:

We want you to engage with us. We will encourage the Minister, publicly as well as privately — you can check Hansard — to engage with the trade unions, to keep you abreast of what is happening and to have a consultation process that is not just about delivering bad news to you first but about listening to what you have to say and taking that on board when decisions are being made. We have been consistent in that approach as well.

Mr Dunne:

For clarification, do you concur that there is a shortage of junior doctors in the Belfast Health and Social Care Trust?

Mr McAdam:

Yes, it is a fact. The question that you ought to be asking is: how did that happen? In my view,

it is an unacceptable fact.

Mr Dunne:

So, you do concur that there is a shortage in the Belfast Trust.

Mr McAdam:

As I said, it is a fact.

Mr McCarthy:

I raised the matter with the Minister and the permanent secretary when they were before the Committee, and I asked them why they allowed the situation to happen. We were told that it was planning, etc, and that they could not get doctors and nurses from Europe because of some working conditions. However, the situation should not have been allowed to get to that stage in the first place.

The Chairperson:

Lads, thank you very much for coming to the Committee. We look forward to seeing you again and to having more robust exchanges.