Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

January Monitoring Round: DHSSPS Briefing

11 December 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Ms Catherine Daly	Department of Health, Social Services and Public Safety
Mr Seán Holland	Department of Health, Social Services and Public Safety
Ms Julie Thompson	Department of Health, Social Services and Public Safety

The Chairperson: OK, folks. Thank you. Seán is getting a long run of it today. You are very welcome, Julie, Catherine and Seán. There is a departmental briefing paper in members' packs. I will hand over to you to make a presentation, and then we will open it up to questions.

Ms Julie Thompson (Department of Health, Social Services and Public Safety): Thank you for the opportunity to provide evidence to the Committee today on the Department's participation in the January monitoring round. To start, I think that it would be helpful to recap on some key points of the process.

First, as we outlined in the briefing paper, the Department has been granted certain flexibilities in the management of its budget that are not available to other Departments. Those flexibilities mean that, when it comes to monitoring rounds, the Department's participation is different from that of others, in that we are not permitted to table bids for current expenditure, except in the event of major and unforeseen circumstances, but nowhere are we expected to declare reduced requirements.

Secondly, any allocations made through monitoring rounds are typically non-recurrent in nature, meaning that the funding needs to be used in the current financial year.

Against that background, I will now outline the Department's proposed approach to current and capital expenditure. In looking at current expenditure, we have considered a range of factors, the most significant of which is the financial context for 2013-14. As previously highlighted to the Committee, the Department, the board and the trusts have been working closely to identify opportunities for delivering cash-releasing productivity improvements in order to address the considerable financial pressures in 2013-14. We still have a funding gap, which we continue to work hard to address. The extent of the gap at this stage of the financial year means that we are submitting bids of some £67

million in the January monitoring round. That includes resubmitting a number of bids that were not successful in the October monitoring round on the basis that those pressures remain. They include £7 million for transition funding for Transforming Your Care (TYC), £12 million for elective care services and £20 million for clinical negligence settlements.

For transitional funding for TYC, members will recall that the Department received £9·4 million in the June monitoring round against a total bid of £28 million. The proposed bid for January monitoring reflects the amount of funding that can be spent between January and March 2014.

For elective care, additional investment is needed at this time to improve performance across a range of regional specialities, including orthopaedics, general surgery, gynaecology and ophthalmology.

For clinical negligence settlements, our assessment is that additional non-recurrent funding of £20 million is required to address the unfunded financial pressure arising from the settlement of clinical negligence cases in 2013-14. That is because some £36 million has already been incurred to date in 2013-14, compared with the full year out-turn of £26 million in 2012-13. As the briefing paper sets out, there has been a significant increase in the number of individual cases that have been settled in excess of £0·5 million.

In addition to those bids, we have also been working with the board to identify the areas where trusts are experiencing unplanned service and financial pressures in 2013-14. As a result, we have identified the following proposed bids: £11 million for unscheduled care and winter pressures; £7 million for the safety and quality of services; £5 million for children services; and £5 million for domiciliary care services.

In-year funding of £11 million is required in 2013-14 to manage increased demand during the winter months and to address pressures that have arisen with unscheduled care and emergency admissions. That funding would be used flexibly by the trusts to provide additional hospital capacity, extended coverage for a range of health professionals, enhanced diagnostics, enhanced intermediate care and community packages, and ambulance initiatives.

A total of £7 million is required to support a range of work that is being taken forward to improve the safety and quality of patient care across all settings. In particular, the funding would support work being progressed across the nursing and midwifery workforce through a period of significant change, following the focus on the outcomes of recent inquiries, such as the Francis inquiry and the Winterbourne review report. As a result, trusts are now incurring unavoidable increases in their staffing levels.

Trusts face increased service pressures on children's services as well. That pattern has been emerging nationally over the past few years and is reflected in an increase in the number of referrals to social services and a significant increase in the number of referrals requiring follow-up in the form of further assessment and intervention.

Finally, there has been a significant increase in trusts' expenditure on domiciliary care services during 2013-14. That is primarily owing to an increase in the demand for those services and the increased complexity in relation to the clients in receipt of care.

At this stage in the financial year, we consider that it is not possible to fund those initiatives and pressures from existing budget allocations without having a detrimental effect on the quality and standards of services for patients and clients. Furthermore, our assessment is that all those bids can be considered as major and unforeseen in the context of the January monitoring round, and that is the consequence on which we will put them forward to the monitoring round.

Turning to capital expenditure, we have been working closely with trusts to determine the overall level of in-year capital pressures. In doing so, we have assessed the timescales for business case preparation, procurement and construction and have concluded that there would be insufficient time to spend any additional funding in this financial year. As a result, the Department does not propose to submit any capital bids in January monitoring.

In conclusion, given the current funding shortfall and the significant savings that are already required to be delivered in 2013-14, our assessment is that it is not possible to fund those additional pressures from existing budgets. All our proposed bids will help to ensure that there is no detrimental impact on front line health and social care services. We therefore strongly recommend that they be considered favourably by the Committee and the Executive. We are happy to take members' questions.

The Chairperson: Thank you, Julie. Is the bid for clinical negligence cases £20 million?

Ms Thompson: Yes.

The Chairperson: What would be the consequences of the Department not having the funds to make payouts?

Ms Thompson: In respect of the consequences, that expenditure is being incurred. As I indicated earlier, and it is in the briefing paper, to the start of November £36 million was paid out on clinical negligence. So the expenditure is being incurred; it is inescapable from that point of view. The consequence is that it would affect the rest of the budget, because we would have to find the money to fund the clinical negligence settlements. At this stage of the year, that would be a challenge; hence the need to bid to the Executive to get the funds through January monitoring.

The Chairperson: It is a sizeable amount. Is the bid to cover clinical negligence cases an increase?

Ms Thompson: It is the same bid that we made in October monitoring. Therefore, to that extent, our forecasts are holding to where we were when we looked at the situation earlier in the year. You are absolutely right: it is a significant pressure. For example, last year we paid out £26 million, and we have already paid out £36 million in this financial year. There has been a significant increase.

The courts are putting a particular focus on clinical negligence settlements, which is leading to more cases, which are being settled at a higher level than previously. When I talked to the Committee during October monitoring, I said that the important thing from the Department's point of view is to learn the lessons long before clinical negligence arises. That brought us into a conversation about the monitoring of serious adverse incidents and ensuring that they are being followed up on an ongoing basis. However, you are absolutely right: any money going to clinical negligence settlements comes from front-line services.

The Chairperson: The TYC bid seems to be in the third tier of the priorities. Given that the implementation of Transforming Your Care is necessary for longer-term reforms and, hopefully, savings, have you considered giving that bid a higher priority?

Ms Thompson: Prioritisation is an issue that the Committee was keen to understand when we were here to discuss October monitoring. It is very difficult: all the bids are high priority from that point of view. They have been ranked according to whether they are inescapable, which is why at the top we have the bids that are being incurred where the spend is already hitting the budget.

Of course, we want the TYC transitional funding to be made available; however, we can scale back the funding and expenditure there to live within the available resources. As I have already explained, the clinical negligence settlements are happening and cannot be scaled back. They are all high-priority bids, but the ranking reflects the inescapability of the bids, and, unfortunately, that means that they have to go in that order. However, you are absolutely right: TYC is a significant priority.

We can scale the spend back in line with the money available, and therefore the inescapable bids have had to go at the top.

Mr McCarthy: Chair, I share your concern about the cost of clinical negligence cases; as you said, it is an horrendous amount of money that could go to other services. This is a silly question, but are efforts made to cut down on negligence in the first place? There must be.

Ms Thompson: Absolutely. Clinical negligence cases, as the Committee will be aware, have a long lead-in time. The cases that are being settled relate to incidents that happened quite some time ago in the health service. You are absolutely right: we need to learn as incidents happen and ensure that the lessons are shared across the system.

The pressure that we are experiencing is from dealing with backlogs of clinical negligence claims in the system, and the numbers are experiencing a spike. Our best information for next year leads us to believe that the expenditure will drop back down. There is a long way to go, but it appears that there has been a spike in the number of cases settled in 2013-14, which we hope not to be in play as we look forward into 2014-15.

Mr McCarthy: You have bid for another £5 million for domiciliary care. What is your expectation? In your report you say that if that money is not forthcoming the result will be new waiting lists and clients being put at risk. Surely, that is the last thing that any of us wants to see. It is important that that bid be awarded.

Ms Thompson: Absolutely. The bids reflect where the service pressures are being experienced, and I am sure that the Committee is aware of that. Therefore, they are being made to the Executive to avoid the implications for waiting lists and people not getting the care that they would otherwise get. So, yes, we welcome the support of the Committee on that.

Mr McCarthy: The Committee has, almost weekly, spoken about the reduced number of people receiving domiciliary care. Meals on wheels is one thing that the Committee is adamant should be protected because, if you do not protect it, the result is that the elderly person will end up in hospital anyway and cause further expense. We will support you to the hilt in getting that for those people.

Ms Catherine Daly (Department of Health, Social Services and Public Safety): It goes back to your point about the prioritisation of the bids. Anything through which we incur expenditure, such as clinical negligence, affects our ability to deliver services, and all of this is absolutely fundamental to the delivery of the transformation. So when you look at this and it is prioritised, it is quite difficult and reflects the overall real financial problem that we have and the need for these bids to be met.

Mr McCarthy: If you can get negligence costs down, you will have £36 million to go to domiciliary care.

Mr McKinney: Can you give me a breakdown of the figures on the overall negligence claims? What is the make-up?

Ms Thompson: To date, the amount incurred is £39 million, and 2,724 cases are open. We closed 461 during the year, and, with the settlement, 150 of those have been settled to date. I could probably find an analysis and provide you with a split by trust, if that is helpful.

Mr McKinney: I was thinking more of the legal bills. What is our legal bill?

Ms Thompson: I am not sure whether I have that with me, but I will provide it for you if that is helpful. I understand that you want compensation and legal bills separated out.

Mr McKinney: Compensation and legal bills, yes. How much of that is the client, claimant or complainant's legal bill? The trust will take a legal position at the start, and we are then into a legal consideration, which concludes with the courts in many, although not all, cases.

Ms Thompson: I can help you. Spend to date in 2013-14 is £29 million in compensation. The plaintiff costs are £6·8 million, and £3·2 million is our own defence costs.

Mr Beggs: You have prioritised them, as we indicated would be useful. However, I think that you need them all, yet you have had considerable in-year success this year to date in each monitoring round. Can the Department cope with the current budget?

Ms Thompson: There are certainly challenges with all elements of the budget, and, where demand is incurred, it will be up to the Executive to decide how the priorities rank alongside other departmental priorities, and they will also consider what moneys they have available from reduced requirements. We await the outcome of that. The prioritisation question is tricky, and that is why we tried to group them a little bit, but it is sometimes difficult to see how one outweighs another. Effectively, they are all needed to protect our service provision.

Mr Beggs: Can I pick up on the £11 million bid for unscheduled admissions and winter pressures? You have prioritised it as a (b), which is an inescapable pressure. If you do not get the money for that from the Department, how can you alternatively get savings to pay for it?

Ms Thompson: We are already committed to delivering £139 million worth of savings from across the whole of the Department, most of which comes from the trusts and the HSCB. Therefore, it is very

difficult, if you like, to find more savings to deal with those pressures. It means that, at this time of the year, the impact on patients is that waiting times might have to increase and that things will not happen as quickly as they would otherwise.

Mr Beggs: What sort of things are this £11 million to be spent on? I am trying to understand what will happen if this does not happen.

Ms Daly: A whole range of things are intended to be covered under this bid, because there are various factors that contribute to the increases that arise from the proportion of older adults in the population; difficulties with the cold weather are one factor. There has been a notable increase in emergency admissions in the winter months, and the key pressures that that poses include the tendency for more complex dependent case mixes, leading to longer stays.

Mr Beggs: I am trying to understand what this money is actually buying in addition to what is currently provided.

Ms Daly: The key thing will be about additional capacity in hospitals to deal with the increased workload. A great deal of it comes down to staffing costs, including extended coverage in emergency departments — nursing practitioners, patient trackers and pharmacists. I could go through a whole range of it, but it really is the staff needed to cope with the additional demand that hospitals face.

Mr Beggs: You are saying that you have to do this, and you are doing it. You are saying that it is inescapable, so, if you are not funded for doing it, what will you cut to pay for it? I am only trying to see what the choice is that faces you.

Ms Daly: You are absolutely right. It is a bubble that is being squeezed. When people present at an emergency department, they have to be dealt with and the demand has to be coped with, but that takes funding away from other areas. I was going to say that the simplest way, although that is a pejorative term in the context, is that you would be looking at increased waiting lists across a range of specialties. Quite simply, this has to be done.

Mr Beggs: Cancelling elective surgery and putting staff towards —

Ms Daly: They are inevitable. We already have significant waiting lists. We have unfunded capacity gaps in the service, and that is what the elective care bid is about. When you look at this, you see that they are not unrelated. If this is not met and demand increases as expected over the winter months, that will squeeze out services in other parts of the service.

Mr Beggs: I think that we have to support every bid here and recognise the pressures.

The Chairperson: OK, folks. Thank you for that. I look forward to the response on the bids.