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COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Evidence Session on Comprehensive Spending Review Efficiency Savings with the Belfast Health and Social Care Trust

15 October 2009

NORTHERN IRELAND ASSEMBLY

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

Witnesses:

Mrs Wendy Galbraith) Belfast Health and Social Care Trust
Mr William McKee)

The Chairperson (Mr Wells):

I welcome William McKee, the chief executive of the Belfast Health and Social Care Trust and Mrs Wendy Galbraith, the trust's director of finance. I refer members to a written submission from the trust and a briefing note from the Committee Clerk.

I also refer members to a written submission from the coalition of nursing recruitment agencies, including Balmoral Healthcare Recruitment, Diamond Recruitment Network, Kennedy

Recruitment and Nursing & Caring Direct. Members will appreciate that those four groups are concerned about the Belfast Trust's decision to cease using agency nursing staff in its hospitals. Their joint submission can be read in connection with the witnesses' evidence.

I invite Mr McKee and Mrs Galbraith to make a presentation, after which members will ask questions.

Mr William McKee (Belfast Health and Social Care Trust):
Thank you, Chairperson. I am grateful for the opportunity to address the Committee. I will give a little bit of background and outline progress over the past two years. Wendy Galbraith will speak about the past six months of this year in more detail.

I have three key messages for the Committee. The first is that we have taken a strategic approach to our financial challenges. Those responses are not poorly thought through; they are neither slash and burn nor salami-slicing. Secondly, efficiencies of the magnitude being sought from the trust cannot be found from reducing bureaucracy alone. We must remove waste across the whole system, reduce duplication, and eliminate unnecessary steps and delays in the patient's journey. Thirdly, 2·7% real growth per annum over the three-year period is not enough to enable health services to stand still.

I will outline the background to the Committee: the Belfast Trust was formed in April 2007 from the merger of six trusts. Together with other trusts, the Belfast Health and Social Care Trust was the first to implement the review of public administration (RPA). We faced a number of challenges, not least of which was the underlying financial difficulties that we inherited. In effect, we began with a deficit of £30 million to £40 million of recurring funds.

We had looked carefully at the English experience, but we did not like the word "turnaround" that tended to be used there, because it implies that a one-off action can return a trust to financial balance. We considered best practice and decided on a strategic approach that we call MORE — maximising outcomes resources and efficiencies — a central process throughout the organisation that aims to do more with less. It is about having the right person doing the right thing to the right patient at the right time and in the right place. We launched MORE in December 2007, just in time to respond to the Northern Ireland Budget 2008-2011, which was voted on in the Assembly in January 2008.

Besides the opening deficit to which I referred, the Budget requires the trust to make 9% efficiency savings amounting to £93 million, which is equivalent to the running costs of three or four average-sized district councils. However, that 9% relates to our total running costs, not 9% of our administration costs.

Our administration overheads, or M2 costs — for what some might call bureaucracy — are carefully audited. Those include all the costs of the board of directors and administrative support; all corporate functions such as finance, personnel, public relations, ICT, communications and estates; and all managers, regardless of whether their professional background is in social work, nursing, medical or general management. Therefore, the figure is extremely inclusive. Nevertheless, the total, externally audited cost of administration comes to a little less than 4% of the trust's total turnover. In other words, I would need to remove all of the trust's administration — or bureaucracy — more than twice over to address a 9% efficiency saving over three years.

It is worth remembering that the Belfast Health and Social Care Trust has nearly 22,000 employees and spends £1,100 million a year. It is, therefore, nearly twice as big as all 26 district councils put together, which employ, collectively, 10,000 people and have an annual budget of £648 million. I am labouring the point, but it is important to say that the district councils collectively employ 26 chief executives, 26 directors of finance, 26 personnel departments, etc. for half the budget of the Belfast Trust. The trust has one chief executive, has already reduced the number of directors fivefold, has already reduced the number of senior managers by more than 25%, backroom administration costs by 25%, and reduced all other professional managerial costs by 12·5%. The trust has done all that on a budget that is nearly twice that of 26 district councils.

We balanced our books in the two previous years: last year, 2008-09, we met our target of comprehensive spending review (CSR) efficiency savings of £25 million, and through a combination of further recurring and in-year savings, we made an £18 million contribution to our underlying financial deficit. Most significantly, perhaps, we treated more patients in those two years than in previous years. Let us be clear: there has been no cutback in front-line services. We have treated more patients in those two years than in previous years and, overall, productivity in hospital services has increased in the Belfast Trust over those two years by 6·7%.

Professor John Appleby, the much misquoted health economist who carried out the review of

health services a few years ago said two things, and people tend to remember only one or other, but rarely both. First, he said that productivity in the Health Service — that is the ratio of all staff, not only administrative staff — against the number of patients treated would need to improve by about 9% to match English performance. Secondly, he said that besides that, real growth of between 4% and 5% per annum was required to allow Northern Ireland to meet its rising health needs.

On Professor Appleby's first point, we are delivering better productivity. It is likely that, by the end of this year, we will have become more productive than England. Of course, we are already more productive than Scotland and Wales. With regard to his second point, we have been let down, because real growth in health and social care is barely 1% per annum over the current three-year budget. John Appleby is not the only person to say that: every commentator on health systems in the developed world says that one needs a minimum of 3% real growth each year just to stand still. That growth is needed to deal with rising expectations, new drugs, treatments and interventions and, in particular, the inexorable demographic that people are living longer. Elderly people who are very frail have exceptionally high healthcare needs that require considerable resources.

Having made those general points, I hand over to Wendy Galbraith, who will give a little more detail about her experiences this year.

Mrs Wendy Galbraith (Belfast Health and Social Care Trust):

Our financial plans for this year were submitted to the Department in early April, and they highlighted two aspects: the underlying deficit that William mentioned of around £40 million and the removal of a further £31 million as a result of our 2009-2010 CSR efficiency target. The £31 million brought our total CSR target to £56 million. William has already mentioned the MORE programme, which is the vehicle by which we intended to deliver on both our underlying deficit position and our CSR targets. Members have papers detailing that programme

It is important to highlight two of the assumptions in our plan. First, the plan excluded the impact of the money that would be required to allow the organisation to deliver the waiting-list targets. Therefore, we excluded that and assumed that that funding would be provided by the Health and Social Care Board, because it is a reflection of the fact that, organisationally, we are recurrently funded to deliver a particular level of activity to deliver the targets. The increasing

demand and the fact that Northern Ireland does not have the capacity to deliver in some of those areas meant that we had to deliver additional work in-house and through the independent sector carrying out additional operations.

I will come back to that, because it reflects some of the increasing demand issues that William McKee mentioned, which were caused by our not having growth of between 3% and 4%per annum.

The plan also assumed that the service could address the in-year pressures by using its existing resources. It is important to talk the Committee through a few examples of that. Since the start of this year, we have engaged with the Department and the new Health and Social Care Board on the assumptions that we made as part of our plan. We have also carefully monitored our financial position monthly. Several of the assumptions that we made at the start of the year have changed, and several significant new pressures have hit our organisation this year.

Therefore, although the trust is still on target to meet its CSR commitment of £56 million, the year-end forecast has risen to approximately £23 million, and there are three main reasons for that. First, through our discussions with the board, we received some additional income, but some of our other assumptions have not come to fruition. Therefore, the net change in our resources is a £4 million increase. However, there have been additional costs in the system. In line with all other organisations, we continue to face substantial pressures on pay and on costs for goods and services. William referred to issues caused by insufficient real growth; the pressures that we are experiencing in the system are well in excess of that. As I said, the assumption was that the service could live within that growth.

I will detail two of a range of examples, many of which are demand-led and externally applied and, therefore, not within our gift to manage proactively. As an organisation, we rigorously and robustly address any waste and identify any areas in which we can make efficiencies and change our services within the organisation.

However, several elements are outwith our control. For example, HIV drugs are a range of life-preserving drugs and therapies. It is estimated that at the current rate of prescribing and taking into account the estimate of how many new patients will enter the system, the spend on HIV drugs will be more than £1 million higher than the specific funding that we allocated for that

purpose.

A non-clinical example is the application of sewerage charges, which were brought in last year and applied at a rate of 50%. Last year, the organisation was hit with a bill of £900,000 and the full charge of £1·8 million has been applied to us this year. Again, there has not been any additional in-year funding. That is a fixed cost and is not something about which we have a choice.

The third issue that has had an impact on our financial position this year is slippage on the MORE programme. We are achieving the £56 million CSR commitment, but we are not achieving the £25 million that we hoped would start to address our underlying deficit. At the start of the CSR period, we knew that we had an underlying deficit position, so we implemented the MORE programme to take a strategic approach. We required three years for that programme. Last year, we received bridging moneys to reflect that we were embarking on a three-year plan, but that money has not been available this year.

As William McKee said, the MORE programme is the appropriate vehicle for delivering the required reform and modernisation — we will not achieve that through a reduction in bureaucracy, so we must reform and modernise our services. The unprecedented pace and scale of change has not been deliverable in the set timescale. The implementation of the programme is the right action, but we have been hit by the timescales. We identified that early this year and, as an interim bridging measure, implemented an increase in our vacancy control target. Several measures that we implemented are starting to be felt across the organisation. Those measures have been a factor in some of the recent publicity and, perhaps, in the letter to which the Chairperson referred.

However, I reiterate that our approach has been to maintain and improve the services to the patients and clients whom we serve and to protect existing employment. Even with the corrective action that we have put in place, slippage against our target remains inevitable.

However, from our perspective, it is important to note that not all of the slippage has been within the control of the organisation. Significant slippage took place on a regional programme that was set to improve procurement efficiencies across the Health Service. We spend significant amounts of money, and it is imperative that we maximise our buying power. However, we have

been delayed in doing that, and several assumptions have not manifested themselves. We have not been able to reflect those in this year.

Secondly, as a consequence of the responses to the consultation process and our agreement with key stakeholders, it became clear that the support did not exist to take forward several of the key reform and modernisation schemes in the time frame that had been proposed. The issue is one of timing, not our general direction of travel. The responses to our consultation and our document 'New Directions' have been positive about our direction of travel. The timeline is the potential issue.

In summary, our current estimates project a deficit for the year end of £23 million, and we are required to pull together a contingency plan. I do not propose to go into the detail of that now; the plan is currently being considered by the Health and Social Care Board, and it will make formal recommendations to the Department and the Minister.

However, I will mention one of the higher profile proposals: one piece of work suggested that, we could, in theory, deliver the same level of services in a different way across central Belfast with 150 fewer beds. A significant amount of comparative research has been carried out in that area. Work was based on each of our specialties, which showed that a length of stay could be achieved that was comparable with the top 25% of similar hospital services. That is based on reforming and modernising our processes, which was a key tenet of the MORE programme. We must reform and modernise.

That is at the core of ensuring that patients do not lie in hospital beds unnecessarily. Before people come into hospital, investigations and tests must be carried out to understand why they are being admitted. People must be brought into hospital on the day of their operation, rather than a few days before. The number of operations that are carried out on the day of admission must be increased.

We are embarking on a journey, and we are keen to pilot those changes in several areas to prove that they will not have a detrimental impact on patient care and that, in a number of areas, they will enhance the patient experience.

In conclusion, I hope that the recent round of meetings between the Health Minister and DFP,

and the review of other budgets across the health and social care system, will deliver some additional resources to enable us to address our shortfall. However, I caution that we cannot focus only on this year. Given the challenges of the next CSR, it is vital that, as a system in the public sector, the health and social care system considers how it delivers services in the future and how it can reform and modernise those services. To date, our approach in Belfast has demonstrated a commitment to engagement, to working in partnership and to reforming the services that we deliver as an organisation.

The Chairperson:

Thank you, Mrs Galbraith and Mr McKee. Quite a few members are interested in asking questions, but I shall start off by making a couple of points.

The trusts appear to have a combined deficit of £70 million this year, but there is a great deal of variation between the trusts. The Northern Trust and the Belfast Trust appear to be experiencing particular difficulties. The Southern Trust, however, appears to be within 1% of its target. One suspects that all the trusts face similar pressures. Some have been able to deal with those pressures more effectively than others. In fact, pro rata, the Belfast Trust's deficit is more than twice that of the Southern Trust. What is so different about the Belfast Trust that has put it in the more difficult position of being £23 million short halfway through the financial year?

Mr McKee:

We mentioned a number of issues in our presentation.

The Chairperson:

Are those issues unique to Belfast?

Mr McKee:

One reason for our higher deficit is that we inherited a £30 million to £40 million underlying deficit from the legacy trusts that were merged to form the Belfast Health and Social Care Trust. In addition, some costs are peculiar to the Belfast Trust and do not apply to other trusts. Wendy Galbraith gave the example of HIV drugs, which are associated with the service that is provided in Belfast to the whole of Northern Ireland, and there are many other examples. Moreover, the Belfast Trust is nearly twice as big as any other trust in Northern Ireland, so care must be taken when making comparisons.

The Chairperson:

I am intrigued to know why the high-profile announcement of the proposal to close 75 beds in the Belfast City Hospital and 75 beds in the Royal Hospitals was made. Is that proposal aimed at delivering the bulk of the savings that you are required to achieve, or have you been spreading other savings, of which we are unaware, throughout the trust?

Mr McKee:

I said that the trust's administrative costs — the bureaucracy — amounts to less than 4% of its total costs, yet we have to find 9% savings. When one looks at best practice elsewhere, people say that savings cannot be found solely by attacking bureaucracy. Our track record on reducing bureaucracy is very good; we have met all our Government and CSR targets. One must look at reducing duplication, minimising waste and delay, and improving patient experience throughout the system. The evidence from other hospitals is that we could reduce the length of stay and, therefore, redeploy staff to treat other patients. We have been taking a range of actions across the whole £1,100 million organisation. We have to do that because we cannot focus solely on administration.

The Chairperson:

Is administration taking any hit in that process?

Mr McKee:

As I said, we have met all our Government targets on administration: we have reduced the number of chief executives from six to one, the number of directors fivefold, the number of bureaucrats by 25%, and the number of other managers by 12·5%. Administration is taking a disproportionate hit on the efficiency savings that we must find. However, even if I were to remove all my administrative, or bureaucratic, costs, I would still only achieve less than half the total savings that I have to find. I would be left with no one in payroll to pay staff, no one in personnel to process recruitment competitions and no one in ICT to manage the trust's 400 servers throughout Belfast. I have to look across the piece, and that includes examining how efficiently we use beds.

The Chairperson:

It is not actually 9% savings; it is 3% savings for each of the three years.

Mr McKee:

Yes, but the savings must accumulate to 9% over the three years.

The Chairperson:

You could create the impression that you are expected to find 9% this year, rather than the standard 3%.

Mr McKee:

It is a three-year budget, and I am required to find 9% savings over those three years.

The Chairperson:

There are CSR efficiency savings and the particular issue of the £23 million. Although those matters are not directly related, I am sure that you would argue that, if you had not had to make the efficiency savings, you may not be £23 million overdrawn. Has the pain of that £23 million been spread throughout the trust, or are you specifically targeting 150 front-line beds to achieve that saving?

Mr McKee:

We are not targeting front-line services. In fact, the evidence is that front-line services have increased over the past two years; we have treated more patients with fewer staff. In the past two years, our productivity has increased by 6·7%. We have treated more patients than in previous years, and we have done that with fewer staff and by thinking of innovative reforms to deliver health and social care. I am proud of how the 22,000 staff that I serve have responded to the challenge of finding new ways to deliver the same amount of care for less money.

The target is 3% per annum, but, of course, over three years, it accumulates to 9%, and it is entirely fair to say that. However, the level of real growth required to deal with increasing demand is just over 1% a year. On average, it is 1·27%. This year, we have had about 0·5% of real growth. That is why we are experiencing difficulties. We do not have enough real growth to allow us to stand still, never mind respond to other pressures.

The Chairperson:

I have quite a few more questions, but I am sure that other members will ask them.

Ms S Ramsey:

I welcome you here this morning. You will appreciate that many questions will be asked, which is why we agreed to start the meeting earlier than usual.

William, in your presentation, you said that there have been no cutbacks in front-line services and an increase in productivity. As I have several questions, should I ask them all at once?

Mr McKee:

Whatever way is convenient for you.

Ms S Ramsey:

If there have not been any cutbacks in front-line services, why is there an outcry about their being cut? The unions told us that there is an outcry. All over the media, including the radio, people are saying that front-line services are being cut. Will your statement still be true when 150 beds have been closed and mothers are being sent home nine hours after giving birth? I do not know who made that decision, but, if a mother is sent home nine hours after giving birth, that represents a cut in front-line services.

Last Thursday, the union representative said that we are not far away from having a Baby P case. I know that we are mainly talking about the acute sector at present, but we need to investigate whether there are also issues in social care.

Wendy said that we are on a journey that need not have a detrimental impact on patient care, because it is a matter of maintaining and improving services and protecting staff. I do not disagree. My question is about private contracts. The Chairperson and John McCallister were on 'The Stephen Nolan Show' this morning. An NHS employee phoned the show and mentioned the issue of private contracts, specifically maintenance contracts. How much do they cost?

You also mentioned research. Is that done in-house? Given that you have 22,000 employees, I hope that it is. I refer to the research that provides you with all of the figures that you have mentioned. You need to tell us whether you discuss HIV drugs, which is a regional service, with the Department, the Minister or the pharmaceutical company, because we need to examine that contract.

I do not know whether you have seen this morning's 'Irish News', but it contains an article in which Dr Brian Patterson states that bureaucracy is killing the NHS. He says that there are 40-plus managers. The head of the British Medical Association (BMA), although he is due to retire, says that there is too much bureaucracy. How are we expected to believe that there is not?

I have another question, which I think is fundamental. The Committee will have the opportunity to ask the Minister and the permanent secretary further questions this afternoon. Has the trust carried out an Equality Impact Assessment (EQIA) on any of the proposed budgets in relation to cuts, reallocation or moving? If not, that must be done. If an EQIA has been carried out, we need to be told of the impact, or alleged impact, that cuts will have on services.

I am conscious that other members want to ask questions. We need more information about the nurse bank, because the evidence that I and other members have received is that the bank closes at 5.00 pm, which means that there is a reason for using agency staff. However, why are agencies being used when the Belfast Health and Social Care Trust has 22,000 employees?

Mr McKee:

Sue, let me assure you that, if there are further pieces of information that you wish to have, we will happily furnish you with them through the Committee Clerk.

Ms S Ramsey:

I have serious questions that require answers.

Mr McKee:

I can do simply restate that, in the past two years, we have treated more patients than in previous years, and there has been no cutback in front-line services.However, a bed is not a front-line service; the number of patients that are treated is what counts. We have treated more patients in the past two years than in previous years, and quality has improved rather than declined. Hospital-associated infection rates have decreased, and we are meeting the Minister's challenging targets to reduce healthcare-associated infections.

I assure the Committee that we are discussing maternity services with internal and external stakeholders. Those discussions are driven by the fact that the average length of stay in the Royal

Jubilee Maternity Service is about 3·3 days, whereas it is slightly over two days in hospitals in England. The rationale behind why the Health Service should meet a 9% efficiency saving over three years is that it was not as productive as England and, therefore, should improve its productivity. However, that relates to the productivity of all staff, not to the productivity of administrative staff. Some women already choose to leave hospital within six hours of delivery, but maternity hospitals in England have programmes whereby women leave the hospital one hour after leaving the delivery suite.

Ms S Ramsey:

That is their choice.

Mr McKee:

That is their choice, and that is how the system will work. Women will choose; leaving early will not be imposed on them. However, the number of births has increased in the Royal Jubilee Maternity Service, and we are not fully funded for that growth. It is better to consider the options than to outline a monthly quota and book a certain number of mothers each month up to our capacity. Allowing women to choose is a better option for the hospital than imposing an artificial cap based on the substantial increases in the number of births in central Belfast. We are discussing that proposal at the moment.

You mentioned the 150 beds. As Wendy said, research suggests that we could treat the same number of patients to at least the same standard and improve their experience. People do not want to stay in hospital longer than is necessary. It would be good to organise their stay better. It reduces the chances of picking up an infection and allows us to redeploy staff.

Ms S Ramsey:

Was that research carried out in-house?

Mr McKee:

Yes.

Ms S Ramsey:

Definitely?

Mrs Galbraith:

Yes, it was a benchmarking exercise that was carried out by us and the specialists. We contacted comparable peers in each specialism, and the research was carried out in-house.

Ms S Ramsey:

Was a private consultant involved?

Mrs Galbraith:

No.

Mr McKee:

You mentioned Baby P. Our child protection services have been audited and assessed. Of course, I can never say never; tragic incidents will happen regardless of the strength of our child protection services. However, I am proud of the quality of childcare and child protection in the Belfast Trust.

As a public servant, the best that I can say is that, by the end of the year, we will be more productive than England. That is, frankly, not something of which we should be proud. If growth continues at barely 1%, we will not be able even to stand still. As a public servant, that is all that I can say. I welcome the independence of trade unions on the matter, and they can say more.

We have reduced the number of in-house works maintenance people in order to buy outside contracts; it is common for all organisations to make that adjustment. It is cheaper and more flexible to rely on outside contractors for routine work and use our in-house team for emergencies and rapid response.

We have had discussions with our funders about HIV drugs. The provision of HIV drugs is a regional service. When we discussed that issue previously, the funders told us that no more money was available for HIV drugs.

The BMA has been the most successful trade union of the past century, and Dr Brian Patterson has played his part in that.

The Chairperson:

We all agree with that.

Mr McKee:

I work according to the facts. The total cost of all bureaucracy — the backroom staff, the managers and support for my board — is less than 4% of the trust's total turnover. It is very low, and those services have, rightly, taken a disproportionate hit. We have made the savings required by the review of public administration, and I have compared those with other public sector bodies in Northern Ireland.

Ms S Ramsey:

What about an equality impact assessment?

Mr McKee:

Sorry. We carried out a complete review as part of the MORE process and in the course of consulting on our CSR proposals. That review was brought to a public board meeting at which it was discussed and agreed. I am happy to share that with you, Sue. The trust carried out that review in close co-operation with external stakeholders, not least among which was the trade union movement. I am happy to provide that information; it is a public document.

Ms S Ramsey:

Was an equality impact assessment carried out?

Mr McKee:

There was indeed.

Mrs Galbraith:

An assessment was made for the MORE programme. It is referred to in one of the appendices to the submission provided to members before the meeting.

The Chairperson:

Agency nurses have raised two points of concern with the Committee. The first is that the staff bank closes at 5.00 pm. Therefore, if someone due to work a night shift calls in sick, extra cover

cannot be obtained. Secondly, how will the trust use its existing staff to cover the phenomenal number of hours — approximately 260,000 — that were covered by agency staff under the old scheme?

Mr McKee:

I will make three points in reply to that. First, you referred to the "phenomenal" number of hours, but every number in the Belfast Trust are high because of its size. Secondly, one of our main objectives in addressing our CSR targets and other financial difficulties is to protect the employment of existing permanent staff. Although I am not permitted to say "never", I have repeatedly told staff that we have no plans for compulsory redundancy and that any early retirement will be voluntary and targeted at certain groups of staff.

Hence, as we have less money and have to live within our budget, we will cut overtime, withdraw agency staff and even reduce the extent to which we use bank nurses in order to protect the existing employment of permanent staff. We may even have to employ slightly more permanent staff to offset a reduction in agency working. Agency staff cost us more than permanent staff, and permanent staff are the trust's staff. Frankly, I would prefer — and I think that it is the right thing to do — to adjust the ratio of permanent to agency staff, but within our budget.

The Chairperson:

Nevertheless, the trust has enough money to employ extra nurses, if required.

Mr McKee:

No, we do not. However, we can reduce our agency staff quite a bit and then employ a few more permanent staff.

The Chairperson:

What happens when additional staff are needed after 5.00 pm?

Mr McKee:

That involves the bank-nurse arrangement. It is staffed only until 5.00 pm, but it is a highly effective way of enabling us to redeploy scarce resources. We do not have plans to keep it open any later, because the number of times that we have to make adjustments after 5.00 pm is

relatively small, and a cost-benefit analysis applies. I am happy to take that point on board and to review the hours applied to bank nursing arrangements and consider whether they should be extended.

Mrs I Robinson:

I apologise to members and witnesses for being late, but I was dealing with an urgent problem. You are welcome, William.

I listened to your answer to Sue Ramsey's question about bed numbers. Everyone in Northern Ireland accepts that we have an ageing community. That gives rise to the need for more beds. If we take that to its logical conclusion, we should not be reducing the number of beds. We should be keeping what we have. In fact, we need more beds.

For the Belfast Health and Social Care Trust to reduce its beds, it must push the length of stay of patients to the lowest limit, which causes me great concern. That is because, on occasions, I have been at the butt-end of being put out of a bed too early. How many patients on the waiting lists, which the trust is reviewing, have returned to hospital with recurring problems? Mothers, who have just given birth, for example, may haemorrhage or experience major gynaecological problems, and other people may be sent home too early and have to return to hospital in a weakened state. Are such patients included in your calculation of how many people you treat?

Mr McKee:

You made a number of important points, Iris. For some years, many previous trusts, and certainly the Belfast Trust in its first two and a half years, have carefully recorded the number of readmissions within 30 days I do that as an assurance to my board of directors that we are not discharging people too early. That number has not increased. In fact, the overall readmission level is lower than that in England. The best objective evidence is whether the number of patients who are readmitted within 30 days has increased, and that is not the case.

You made a point about the growing number of elderly frail people —

Mrs I Robinson:

May I have the readmission figures, William?

Mr McKee:

Of course, they are in the public domain; we publish them every other month at our board of directors' meetings.

Our focus is to support the growing number of elderly, frail people in their homes or in the community, not to rely on inpatient stays. Many acute beds in central Belfast are occupied by older people.

When I was here last, I told the story of my late mother-in-law who had an operation for cataracts 15 years ago and spent four days in hospital. My mother — now my late mother — had the same operation 18 months ago and stayed in hospital for four hours. They were both elderly people, and my mother-in-law hated spending four days in hospital, whereas my mother thought that her four-hour experience in hospital was pretty good. I misjudged how long the procedure would take and was late in arriving to collect her, but that was the only bit of the experience that she did not enjoy.

We must move with the times. If, by managing the patient journey just a little more tightly, we can treat the same number of patients, or even slightly more, with fewer beds, we should do so.

Mrs I Robinson:

I take the point that, as you rightly suggested, some elderly people can be in and out of hospital within four hours, but I am talking about frail, elderly people who have broken limbs and cannot be left in the community. We cannot say that everybody can stay at home. People with illnesses such as kidney or bowel complaints or cancer need attention, and, as one gets older, multiple problems arise.

Mr McKee:

We are dealing with layers of complexity, and no business is more complex than trying to run a health care system. Most improvements in the use of beds are in planned admissions, not in emergency admissions in which, for example, an elderly person has broken his or her femur or has had an acute medical episode. The bulk of bed savings will come from planned admissions, for which we ought to be able to predict the nature of the stay. Many outpatient tests can be carried out before admission rather than in the two days during which a patient is waiting for a

planned operation. Nevertheless, I take your point.

Mr Easton:

Thank you for your presentation. I will try to stick to the subject of efficiency savings. Last week, the Ambulance Service Trust gave a presentation to the Committee. The trust told us that it had sent a second set of proposals to achieve its efficiency savings to the Minister. He agreed the proposals and — Bob's your uncle — the story of what will happen in the Ambulance Service came out in the press.

However, the Committee was not told about that second set of proposals; we did not see them or even know that the Minister had received them. Therefore, we felt a wee bit annoyed that various aspects of what is happening in the Ambulance Service came out in the media. We knew nothing about it and did not have a chance to speak to the Minister about the second set of proposals. Have you sent a second set of efficiency proposals to the Minister? Has he agreed them, or are you waiting for him to come back to you?

We have heard second hand about mothers leaving maternity departments nine hours after giving birth and about the reduction in beds. It is unfair to the Committee not to have known about those changes. That makes it difficult for us, particularly as the changes were given media coverage. I do not know whether those changes have been agreed with the Minister. If not, however, how do the media know about them? The documents are confidential.

As for the closure of 152 beds, the Committee received a guarantee that the affected nursing positions would be utilised elsewhere and that there would be no cuts. That is a major issue for me; I declare an interest as my sister is a nurse.

Have you calculated the cost differential between agency and bank staff? Are agency staff cheaper or more expensive overall? Although I agree that the cost of agency staff must be reduced, I am concerned that you have moved to a zero policy on agency staff. Without the availability of bank staff to cover certain periods, I am also concerned about the shortfall in hours. Has the number of agency staff been cut right across the board, and does that include clerical staff?

You said that administration costs make up 4% of your entire budget, and I am happy to agree

that that is the case. However, the audited accounts show that there has been an overall increase in trust management costs from 13% to 25% right across Northern Ireland. Why has that increase occurred after a reduction in the number of so-called managers? In certain trusts, I have found that managers have been moved to other jobs. They may no longer be employed as a chief executive or manager, but in a new type of pay-protected management position. It is startling to find that, although managerial positions have been removed, people return to carry out similar jobs but with different titles.

Finally, will there be 1,745 job reductions over that period and, if that is the case, will there be voluntary redundancies or will staff simply not be replaced? How will that work?

Mr McKee:

I will do my best to rattle through those questions. Alex, we call the supplementary plan our contingency plan, and we were required to submit one. As Wendy said, that is being considered by the new Health and Social Care Board, and the board will make a recommendation about our and other contingency plans to the Department and the Minister.

Mr Easton:

Have you agreed to anything yet?

Mr McKee:

No, not at all. I am required to engage with staff, particularly staff organisations. However, I do not need to be required to do so because it is good practice to engage with staff. I cannot deliver good quality health and social care without engaging with the 22,000 staff whom I serve. As part of that engagement, we have talked in detail and generally about the proposals so that they will have some credibility when we make them.

I am not accusing anyone of deliberately leaking information. Nevertheless, I briefed more than 1,000 staff face to face in nine separate meetings in the past couple of weeks, and I have to engage with as many of the 22,000 staff as I can. It is inevitable that those proposals will come into the public domain.

Mr Easton:

You can understand that the plan came as a shock to the Committee.

Mr McKee:

Yes.

On the subject of beds, I can only repeat that the evidence on paper is quite stark that we ought to be able to treat the same number of patients with fewer beds. We would like to pilot that in a number of areas to demonstrate that it can be done. The whole point is to be able to redeploy staff elsewhere within our budget.

Mr Easton:

So no nurses will be —

Mr McKee:

My second point is that we have no plans for compulsory redundancies, and we have no plans to offer voluntary early retirement or voluntary redundancy to the basic nursing grades. We are managing the situation by recruiting slightly fewer people than we have vacancies for month on month and by cutting back on agency staffing, overtime, etc.

That leads on to your next question. Agency staff are more expensive, and Wendy can give the details. We have, probably, been relying too much on agency staff. We have tried to turn the situation round by taking a zero-based approach and starting from the premise that we will not use any agency staff. We will have to use some agency staff, but that will be the exception, rather than a matter of routine or the norm. That will be the situation right across the board and not only for nursing agency staff. Wendy, would you care to speculate on the premium on an agency worker?

Mr Easton:

There could still be a reduction in the number of nurses. You do not intend to make them redundant, but you may not fill a vacant post.

Mr McKee:

We may not fill all our vacancies. We must fill them at a slightly lower rate than the number of vacancies that emerge through turnover and natural wastage. Wendy has just told me that there is about a 10% premium on the use of an agency worker compared with one of our employees.

On the subject of managers, you must forgive me, but it is hard to respond to anecdotal evidence. The total number of managers has not increased; it has decreased substantially. However, managers, as with other staff, have had changes made to their superannuation. They make a bigger contribution and the employer makes a bigger contribution, and they are subject to the new Agenda for Change terms and conditions. As with other staff there have, on occasions, been back payments. Therefore, the total cost for a particular year may have increased but that is because of the new terms and conditions introduced nationally and because superannuation has changed. The cost for each member of staff has increased because the employer's contribution to superannuation has increased.

We have met our CSR and RPA targets and substantially reduced the number of managers and administrative staff — by far more than we seek to do with other staff groups.

Mr Easton also asked about job reductions. When I was last here, it was on the back of a submission that we had made to the Committee. Our submission outlined the job reductions and the offsetting of those by the small amount of additional staff who will be newly employed as part of the small growth in real terms in the health and social care budget. Those documents were made available to the Committee some months ago, and I am happy to make them available again.

The Chairperson:

With regard to the 10% premium on agency nurses, have you built in a factor to cover the administration at your end, or are you simply taking wages into account? It has been alleged that the simple cost of bringing in agency workers is not the true cost to the Belfast Trust, because someone must administer the recruitment and oversee their work. That invisible cost is not taken into account in the premium.

Mr McKee:

Of course, we have to oversee the work of agency staff. Dare I say that the coalition of agency contractors would say that, would they not? It is widely acknowledged that we have been relying too much on agency staff recently — not only in nursing but elsewhere. Given the 9% efficiency savings we must find over the three years, we are trying to build flexibility into our total workforce costs as part of having to reduce our total numbers substantially. We are rebalancing

the situation partly because we have current financial difficulties and partly because we have been relying too much on agency staff anyway. We said that we would like to reach the point of zero usage of agency staff. We will not get to zero, but we will employ agency staff as an exception rather than as the norm or as a matter of routine.

The Chairperson:

Is the press coverage of a complete ban on agency staff not correct? Is it the case that you now have to put forward a business case for recruiting them rather than automatically ringing up the agency?

Mr McKee:

My senior budget-holders are interrogated regularly on their use of agency staff. They are asked to justify why they have used agency staff and to show that they have done so as an exception rather than it being the norm. Our use of agency staff is subject to tough internal peer review and auditing. The use of agency staff is not at zero, but I hope that, to help us meet our statutory duty to balance our books, it will be reduced substantially.

The Chairperson:

Members may have noticed that I have given priority to members whose constituencies are covered by the Belfast Trust. The same favouritism will be shown when the Southern Trust gives its evidence; members whose constituencies are in that area will ask their questions first. Obviously, expertise on the work of the Belfast Trust lies with two or three of our members.

Mr Gardiner:

Mr McKee and Mrs Galbraith, thank you for your presentation. It is great to see you here again. Rather than knocking you, I congratulate you on the efforts that you are making. Having said that, if the cuts had not come about, you probably would not have made those efforts. I welcome the action that the Belfast Trust has taken as a response to being subject to a cut of £23 million.

I understand your comments about agency staff and how you have to make cuts somewhere. I am sure that the people of Belfast and its locality and everyone on the Committee would wish me to record their appreciation of your work that goes on and the high standard of healthcare that you deliver in your hospitals. Today's meeting is not an exercise in knocking you; it is designed to encourage you to try to work within a budget and raise standards.

Mr McKee:

I am immensely proud of the work of the 22,000 staff in the Belfast Trust. It is my privilege to serve them, and I shall pass on those words. They will encourage us to try harder to modernise and reform, to make sensible savings where we can and still treat more patients to a higher standard. Thank you.

Dr Deeny:

Thank you, William and Wendy, for your presentation. I have had an interest in the Health Service for years. Many medical and nursing professionals, not only Brian Patterson, still believe that, although cuts may have been made in administration, the issue of cuts remains a major problem in the Health Service. Some people might say that, since the reforms were made under the review of public administration, the Health Service is almost worse off and more over-administrated.

Given the huge public interest in the matter, why not get all the information out in the open? For example, a breakdown of the Belfast Trust's administrative structure could be made public, perhaps in the form of a Christmas-tree or cascade-type diagram. William, such a diagram would show exactly what staff work under you, and how many directors and managers are employed in the trust. Nowadays, people are hugely interested in how much all of us, including MLAs, and indeed GPs, earn, because the money comes from the public purse.

Wendy, you are the director of finance. How many other directors are there in the Belfast Trust? Are you the only director of finance? I note that the Belfast Trust is responsible for almost exactly one fifth, or 340,000 of Northern Ireland's population of 1·7 million. I discovered that another trust has one director of finance and three assistant directors of finance.

I worked with management in the Health Service for years. An excellent manager in the Western Trust who was in charge of the family practitioners' unit retired recently. I recognise, therefore, that good managers and administrators are needed, but my concern as a health professional is that duplication and triplication still take place in administration. I would have thought that one damn good director of finance would be enough. Does the Belfast Trust employ any assistant directors of finance?

Mr McKee:

Kieran, we serve a fifth of the population, but we also serve the whole of Northern Ireland and beyond on a whole range of specialist services. We receive one eighth of the Assembly's total budget for health.

I can deal only in facts. Compared with the previous six trusts, there has been a fivefold reduction in the number of directors in the Belfast Trust area.

Dr Deeny:

How many directors are there now?

Mr McKee:

There are approximately 10, although I would have to track them out on a wee diagram.

Dr Deeny:

I would like to see that.

Mr McKee:

Of course, Kieran, but that information is in the public domain on our website. I have to deal in facts, and, in the past two years, there has been a fivefold reduction in the number of directors in the area covered by the Belfast Trust. We spend twice as much as all 26 district councils put together, yet they have 26 chief executives, 26 finance directors, 26 personnel departments, 26 maintenance departments, etc. We made our CSR and RPA savings, and we are struggling. Our broadly defined administration costs less than 4%, so I simply deny allegations that we are over-administered.

I suggest that one of the reasons why that subject is such a neuralgic issue for the BMA and other staff is that hard choices about how money is allocated in health and social care are left to very good managers and directors, such as Wendy Galbraith and her colleagues. We are left to make those hard choices and, as you know, many people feel that hard choices should not have to be made about scarce healthcare resources; there should simply be enough money to meet people's needs. I have argued today that there are not enough resources to meet people's needs. We do not have sufficient real growth to stand still, so Health Service managers are blamed for the hard choices that should have been taken elsewhere.

You can understand why I am prickly about this subject, because all the evidence points in the other direction. We have made our RPA savings; we have substantially cut the number of managers and the amount of administration. As I said, even if I were to cut out administration twice over, we would not meet our savings target for the three-year period that we are half-way through.

Dr Deeny:

You agree that the public should see the breakdown of staff and staff costs, and you said that that information is on the website.

Mr McKee:

My salary and those of directors have been published for many years.

Dr Deeny:

The Committee should find out the exact position of each of the five trusts, because people are being paid out of the public purse. For years, I have specialised in dealing with elderly people, and I agree with Iris that the elderly population is increasing. Despite all the talk about savings, it worries me that we gauge the success of front-line services by the number of patients that have been seen. That does not paint the full picture. Patients may be seen, but they may not have been seen for long enough, and they may not have been adequately followed up. I have seen some patients being sent out of hospital too quickly and having to be readmitted. Just because greater numbers of patients are seen, one cannot definitively translate that into an improvement in front-line services.

I have not heard much about community care. All the talk is about maternity services in the Belfast Trust, but, believe you me, there is a major concern about mothers leaving hospital.

The Chairperson:

Is there a question coming?

Dr Deeny:

Yes, my question is coming. Many people would say, for example, that a lot of pressure will be put on community midwives. It is more expensive to look after people in the community,

particularly the growing elderly population, than to look after them in hospital. I would like your views on that subject, including details of the allowances that you are making for the increased amount of care that will have to take place in the community.

Mr McKee:

I shall try to think of something different to say than I did in my reply to Iris when she asked that question. I do not measure the success of the Belfast Trust solely on throughput either. However, the premise for the health and social care budget a year and a half ago was that we should increase productivity by 9% in order to match the English.

I also said that we have many checks and balances in place, not least of which is the fact that we carefully record the number of patients who are readmitted within 30 days of a previous admission. Of course, every year, we deal with hundreds of thousands of patients and many more clients in the community. Throughout the year, we have 10 million or 20 million face-to-face contacts with citizens. Sometimes, we get things wrong. However, there is no evidence that treating more patients with slightly fewer staff, as we have been doing, diminishes the quality of service.

We strongly support the premise that we should subtly shift the emphasis from institutional to community care. The little growth that we have experienced has gone towards making that shift. I return to my key point that our budget grows by barely 1% per annum, yet all the evidence is that 3% real growth per annum is needed just to stand still. That is at the root of everything.

Mr McCallister:

I will follow up on a few points. Can we be assured that there is not a blanket ban on agency staff, particularly after 5pm and at weekends when bank staff cannot be contacted? The crux of the issue is that health inflation is outgrowing the increase in demand on the service; the growth in service demand is outstripping your spend. Am I right to interpret what you said earlier as the trust managed to repay £18 million of its £30 million legacy deficit in the first two years?

Mr McKee:

That is correct.

Mr McCallister:

That reduced the deficit to about £12 million.

Mrs Galbraith:

We managed some of the reduction in-year, but we delivered £12 million of it recurrently. We have brought the remainder forward with us.

Mr McCallister:

That represents a significant improvement in your legacy deficit, although the current in-year deficit is £23 million. Where does that leave any new service developments? William, you have consistently made the point that the trust is barely standing still. Will new service developments such as screening be jeopardised?

Mr McKee:

I will take the last point first. There is extremely little growth; it is only about a third of the level in England. However, some new services are going ahead. It is a matter for the Health and Social Services Board to make recommendations to the Minister. After that, we will see whether the current financial situation will have any impact on those services this year or next. New services are not my call, but I labour the point that the development of new services is moving at a much lower rate here than in England, Scotland or Wales.

To be honest, I would like a blanket ban on agency staff, but there is no such ban. We have to use agency staff as an exception, but I do not want to use them routinely or as a rule. One of the problems with barely 1% growth per annum is that it is not enough to deal with healthcare inflation, which is generally much more than allowed for in our budget.

I have addressed more than 1,000 staff at nine separate public meetings. Those meetings were difficult because the staff, of whom I am very proud, are hurting. I told them clearly that no matter how difficult things are, they should do the right thing by putting patient and client safety first. I have told staff that they must make hard choices along with the rest of us, and that they should not fall into the trap of doing something that either breaches their professional code of conduct or runs contrary to using common sense in deciding how best to treat an individual patient. Patient safety is always put first.

Mr McCallister:

We now have a Public Health Agency. Improvements in the awareness of HIV, drugs, and sexual health and the development of an anti-obesity campaign will take time. I hope that the huge demand on the agency will reduce in the long term and that the overall population will become healthier. Do you envisage that care for elderly people, which was mentioned by Kieran and Iris, will be a driver in helping to reduce some of those demands in the long term?

Mr McKee:

I do not want to use overly technical language, John. However, seven years ago, Derek Wanless produced a famous report on behalf of Gordon Brown, the then Chancellor of the Exchequer. In that report, 'Securing our Future Health: Taking a Long-Term View', Wanless commended what he called a "fully engaged" scenario. In other words, if there is real engagement with citizens and other parts of the public sector to try to improve health and well-being, less growth would be needed in the investment in health and social care.

However, the level of growth that Wanless suggested would be needed to meet rising healthcare needs is substantially greater than the investment that we are receiving over this three-year period. We are not receiving investment growth to the extent of Wanless's "fully engaged" scenario. We all want a situation in which citizens take responsibility for their health and in which the education system, the policing and justice system, city councils, and so on play a part in improving people's health and well-being.

The Chairperson:

I invite the two ladies, Sue and Iris, to ask questions. Perhaps William will answer them together.

Ms S Ramsey:

As Sammy said, no one is knocking the good work of staff. We all have hard choices to make. William, you mentioned your meetings with staff. I am led to believe that you informed staff that you were aware of the matter some time ago and that you were asked to keep it secret. I have submitted a series of questions about that to the Minister. I am unhappy with today's presentation, and, as a result, I will forward more questions to the Minister.

On the subject of legacy funding, will you give us a breakdown of how much of the debt was incurred by the various trusts, including the Royal Hospitals Trust? Were any of the chief

executives or senior management of the trusts, and that includes you, held accountable for that debt? That issue needs to be addressed.

Were agency staff banned in any of the trusts, including the Royal Hospitals Trust, prior to their merging to become the Belfast Health and Social Care Trust?

Mrs I Robinson:

I wish to speak about mental health, a subject in which I have a strong personal interest. Considerable efforts are being made to reduce the number of dementia beds. Given that we are an ageing population and dementia tends to occur in older age, that causes me a great deal of concern. I deal with an elderly constituent whose husband has dementia, and she is trying to look after him at home. He used to receive care at a day-care facility, but that was cut because the carers could not lift him when he fell.

I see the knock-on effects that dementia has on family units. Family members give up jobs and everything else in life. They retreat into themselves and assume an insular identity. When elderly dementia sufferers pass away, their relatives are left with a lot of mental-health issues. For the life of me, I cannot accept that the number of beds for dementia sufferers should be reduced. The problem is growing because people are living longer. What are you thoughts about the proposed bed reduction?

Let us nail our colours to the mast and say that community care is a postcode lottery and does not work in many areas. I become irate when I deal with so many people who are trying to cope with elderly family members who have senile dementia or similar mental-health issues. Those people do not receive the necessary assistance, and, eventually, the elderly person has to go into hospital. I am concerned that we are not dealing realistically with the situation: the beds must stay, rather than decline in number. I would like to hear what you have to say about that, William.

Mr McKee:

Thank you, Sue, for your kind words about the efforts of staff. I will happily pass those on.

My memory is that all the trusts that came together to make up the Belfast Trust were balancing their books, but that they relied on non-recurring money to do so. In a way, spending

slightly more money each year, and asking the trusts to do more each year than they strictly have the budget for, is fine when there is steady growth. However, it does not work so well when there is not steady growth. I do not seek to haul any of my ex-colleagues into the stocks over the inherited deficit. It had more to do with the fact that, if growth starts to stall, the in-year problem must be addressed.

Ms S Ramsey:

Given that the deficit is £30 million, we need to see a breakdown, because my next question is about accountability for that deficit.

Mr McKee:

Before the merger, all the trusts used agency staff, usually in proportion to their size and reliance on beds. I acknowledge that, over the past two years, there has been an increase in the number of agency staff in the Belfast Trust. That is because we have been trying to become flexible enough to deal with the challenges of how many of our workforce we can afford. We are now rebasing that, and we will swap some of the expenditure on agency staff for expenditure on permanent staff.

Mrs Galbraith:

I apologise that I do not have the exact breakdown of the £30 million deficit to hand, but we can get that for the Committee.

Ms S Ramsey:

Was anybody held accountable for that deficit?

Mr McKee:

The deficit was being dealt with by non-recurring money, and it was that non-recurring money that dried up. I, and my colleagues who were the chief executives, know that the six trusts were able to demonstrate that they had balanced their books.

Ms S Ramsey:

In that case, why are we dealing with a deficit of £30 million?

Mr McKee:

If an organisation is due to receive more money the following year, it is OK to use non-recurring money. However, as real growth dries up, the underlying deficit must be dealt with. I will happily take time to explain that to the Committee and outline the background to the situation.

Even I, and certainly the staff involved, understand that the choices that staff have to make have a severe impact on people's daily lives. There is a wider issue, in that dementia is growing at a much faster rate than other conditions. We need to focus on that. I am not saying that we get everything right, Iris. However, there is a strong case to be made for rebalancing the number of conventional institutional services and the amount of community support that we provide.

The pressure that we, and other healthcare systems, are experiencing because of dementia is only one of a number of pressures. With growth at barely 1%, hard choices have to be made. All commentators say that at least 3% growth is necessary merely to stand still and deal with the growth in the number of older people with poor mental health or dementia and other pressures The Appleby review put the figure at 4·5%.

The Chairperson:

It has been a bit of a marathon session. I am sure that you found that useful; the Committee certainly did. Thank you for being so forthright and helpful. You were in the hot seat for well over an hour, and members were very interested in what you had to say.