Northern Ireland
Assembly

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

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

15 October 2009

NORTHERN IRELAND ASSEMBLY

_____

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

_____

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

_____

15 October 2009

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 Mairead McAlinden	)	
Mr Stephen McNally	)	Southern Health and Social Care Trust
Dr Gillian Rankin	)	
Mr Francis Rice	)	

The Chairperson (Mr Wells):

Welcome, ladies and gentlemen. We have a team from the Southern Health and Social Care Trust, including: Mairead McAlinden, the acting chief executive, Gillian Rankin, the director of older people's services and primary care, Francis Rice, the director of mental health and learning disability, and Stephen McNally, the acting director of finance.

You were present for the Belfast Health and Social Care Trust's presentation, so you have an

idea of what is involved. Please make an opening presentation and then members will ask questions. I will give priority to those members who represent constituencies in the Southern Trust area and then throw the discussion open to everyone.

Mrs Mairead McAlinden (Southern Health and Social Care Trust):

I hope that members have a short summary of our presentation. I thank the Committee for the opportunity to come here and talk about our efficiency savings. The Southern Trust's profile is as follows: we have almost 13,000 staff; an annual income of £448 million; and we provide care to more than 350,000 people. Members will be aware of our history and context. We have been through some painful changes in the past five to eight years in the rationalisation of hospital services, the closure of facilities such as Banbridge Hospital and the removal of acute services from South Tyrone Hospital. Over a number of years, we have made changes to our provision of services in line with need and in response to changing demand. We are the most efficient Northern Ireland provider trust, as is shown by the reference costs — a process that was undertaken by the Department — and we have a history of being underfunded, as demonstrated by the capitation formula, which is one of the most sophisticated formulas available.

As to our hospital system and the Developing Better Services strategy, we are consistent with that strategy, and we have a hospital network of Craigavon Area Hospital, Daisy Hill Hospital and South Tyrone Hospital, which is a local hospital model. We are proud that we perform well against the ministerial standards and priorities for action targets in areas such as A&E and reducing delay in discharges. In the context of Northern Ireland, we perform extremely well.

We have attended the Committee previously and spoken to you about our priorities for service change, which are in our summary. Providing safe, high-quality care remains the number one priority of the Southern Trust. We have an absolute strategy for promoting independent living, and we work with our users and our staff to improve the quality of our care.

This morning, the Committee heard about the growth situation facing the health and social care sector, so I will not repeat those points. Increasing demand stretches our services, particularly with demographic changes in the Southern Trust area. We have experienced a 35% increase in the number of births in our hospitals over the past five years; our child population has increased by 20% over the past six years — an annual increase of 3%; and our older population has seen an 85% increase since 2007. Our savings requirement is known to the Committee: it is

£36 million over three years. I have spoken to our users and staff about these challenges, and it has reassured people that this money has been reinvested in new service provision.

I will break down our requirement. Some £6 million had to come from administrative and management savings. We have set ourselves a target saving of £15 million from service reform and £15 million from improving our efficiency and productivity. We opened our books this year with a deficit of £4 million, and in-year pressures will add to that throughout the year.

As to our approach to the comprehensive spending review efficiencies, the Committee knows that we held an extensive public consultation process on our five-year strategy, Changing for the Better, which sets out all our major service changes. In addition, the trust has partnered with English organisations to examine new methods of working and the creation of efficiencies, and it is also working with the NHS Institute for Innovation and Improvement to ensure benchmarking against the best health trusts in the UK. The process that the trust has undertaken has involved engagement with staff, trade unions and users to ensure that its services are coherent and in line with best practice.

I will now give the Committee some detail on the trust's progress to date against its three-strand approach of improving efficiency and productivity; examining ways in which the trust can redesign and improve its services; and the ways in which it can generate income.

The trust has delivered its RPA savings target of £6·1 million. The Committee will be aware that the Southern Health and Social Care Trust was formed from four legacy trusts, and, since its formation, it has reduced the number of "top of the shop" positions, or chief executive and director posts, from 32 posts to nine. Furthermore, the non-executive posts that were aligned to those legacy trust boards have been reduced from 24 to eight, and that level of reduction has been seen in the areas of administrative and management support from the top to the bottom of the service.

With respect to improving efficiency, the trust has a strategy in place, Best Care, Best Value, which allows it to benchmark itself against the most efficient organisations in the public sector. Through that process, the trust has managed to improve its patient flow through hospitals, and it has now implemented a "no delay" strategy. The trust has reduced the use of the independent sector to manage its waiting lists, and it has plans to reduce that use even further. The trust has

also entered partnerships with the voluntary sector to ensure that it is providing complementary services, and it is putting those services on a much firmer financial footing to allow the providers of those services to become real partners in care.

On the issue of skills mix initiatives, the trust has examined making the best use of skills. In discussions with professional colleagues, it has been told that, with a small amount of administrative support, much more hands-on care could be carried out, and that has made a significant contribution to the trust's skills mix initiatives. The trust is also examining the streamlining of its administrative processes, and it has centralised the booking process for outpatient appointments.

The trust has made significant efficiency improvements in the area of acute hospital care. It now has 100% coverage for pre-operative assessment, meaning that, before people come into hospital for a planned procedure, they speak to a trained nurse, have their diagnostics completed and are well prepared to come into hospital on the morning of admission. That has allowed the trust to increase its admissions on the day of surgery from 22% to 86% for planned elective procedures, and it has set an additional target of treating 70% of a basket of day-case procedures, moving from a current performance of 63%.

The trust has also eliminated the medical outliers that had caused difficulties in its hospital system, and it has had great success in improving its delayed discharges of patients. I am aware that Committee members believe that people are discharged from hospital too early, but, with the trust's discharge process, the patient is declared medically fit by a trained team of staff and, for 95% of very complex cases, the trust can discharge such patients into safe, effective community packages within two days. For non-complex patients, the trust is currently discharging 96% of patients within six hours, enabling the trust's hospital system to work efficiently and swiftly, and to treat those patients who present at the accident and emergency departments.

I now hand over to Dr Gillian Rankin to discuss the specifics of the care of older people.

Dr Gillian Rankin (Southern Health and Social Care Trust):

With respect to the trust's specific plans for the care of older people, consultations were introduced last winter for the trust's non-acute hospitals and its statutory residential homes. Those proposals were based on the strategic intent of supporting people in maintaining their

independence at home and on the prevention of unnecessary and inappropriate hospital admissions through the development of new community services. Furthermore, both the non-acute hospitals and the residential homes had shown a significant reduction in people choosing to go into residential homes, and there were lower occupancy rates in the trust's non-acute hospitals.

The trust introduced proposals that would reduce the non-acute hospital sites from three to two, reducing, ultimately, to 94 beds over the next three-year period. Furthermore, it proposed to reduce the number of statutory residential places to reflect the number of people choosing to go into residential care rather than remaining at home with 24/7 domiciliary care support.

Those proposals have been accepted with the proviso that we move to two non-acute hospital sites. With the development of Mullinure Hospital in Armagh city as a centre of excellence for older people, that is exactly the process that we are now undertaking. At Mullinure, we are bringing together the services that support people to remain at home and the services that use inpatient beds for people with dementia who need assessment. My colleague will refer to that later.

We are also providing 10 new respite places at residential homes for people with dementia to augment our current provision of respite care when patients and carers need that. Those plans are moving ahead. They will be fully in place later in this financial year, and the full reduction of residential numbers across our five residential homes will be in place by the autumn of next year. It is important to reassure the Committee that all the people in the system who are seeking residential care are receiving, and will continue to receive, access to a residential place either in one of the five trust homes or in the independent sector.

All that is being done in the context of a substantial recent investment and continued investment in community services. I draw the Committee's attention to the new investments in rapid access assessment clinics. In the past couple of weeks, those have commenced in Lurgan Hospital for the population in Craigavon and Banbridge, and they will be commencing in Mullinure Hospital for the population of Armagh and Dungannon.

The clinics provide a multidisciplinary, consultant-led assessment for older people who may require an acute hospital admission or who may be waiting for an outpatient appointment for a small number of weeks. If a GP is concerned about an older person but knows that he or she does

not need an acute hospital admission, the GP can arrange an outpatient appointment that gives the individual access to the clinic within 48 hours or 72 hours.

We are also putting in place early supported discharge teams for people who have suffered a stroke. There is clear evidence in the NHS to support that as an effective means of continuing rehabilitation for people at home. That will inevitably shorten the length of not only an acute hospital stay but a non-acute hospital stay. We are committing resources and developing new services in our three localities.

Future planned investment will continue to provide access to rehabilitation at home, seven days a week, and will consider the development of re-ablement services. Quite often, older people move to different forms of care after they have had a fall or another small event has happened that has triggered a loss of confidence. We are not yet providing a re-ablement service that helps to restore their confidence to enable them to stay at home. However, we are exploring that.

In addition to that investment, there has been continued background investment in domiciliary care; in developing more flexible models of domiciliary care; in carer support; in dementia professional teams; and in our specialist chronic disease management teams. There have been significant investments in recent years, and that investment will continue this year and into the foreseeable future.

Mr Francis Rice (Southern Health and Social Care Trust):

I will briefly detail the plans that were put forward for mental-health and disability services specifically and then describe some of the enablers that will help us with that change.

The specific plans for, and consultations on, mental-health and disability services have centred on the proposal to centralise acute mental-health inpatient care at the Craigavon site. That will provide a 94-bed unit, with services for general acute mental-health patients and functionally mentally ill elderly patients as well as psychiatric intensive care and addiction services. Outpatient services and a newly designed resource centre to provide holistic care to patients with mental-health needs will be co-located at the site.

Resettlement after long-stay hospital care is a historic issue in the Southern Health and Social

Care Trust and has been progressed since 2002. Since then, 76 patients have been successfully resettled from Longstone Hospital, which is a hospital for people with learning disabilities. Fifty-eight patients remain in Longstone Hospital, and we propose to resettle a further 33. The Government target is to resettle 17 learning disability patients by 2011; to date, we have successfully resettled 23. Sixty patients have been successfully resettled from mental-health services at St Luke's Hospital since 2002, and we propose to resettle 39 of the 59 who remain on that site. Moreover, we have already successfully resettled 23 long-stay patients from mental-health hospital care in mental-health services against a Government target of 18 by the end of 2011.

I will outline some other areas that we feel will complement and enable the resettlement process. Several initiatives are ongoing in the trust. Specifically, the establishment of independent advocacy services will represent the needs of patients and clients in the resettlement process and will help us to redesign our services.

The Change in Mind strategy will occasion the development and complete review of mental-health services in the Southern Trust area. It is important to note that the Southern Trust is the only trust in Northern Ireland that takes the view that we need to review all our mental-health services. Therefore, we have initiated and significantly progressed the strategy, the ultimate aim of which is to provide services where and when they are needed. Basically, we will put many services at the front of primary care and community care services and, therefore, only admit patients to hospital who absolutely need to be admitted to hospital. As a result, we have established three core teams that centre on the provision of services for patients who are acutely mentally ill, patients who require recovery, rehabilitation and support services, and patients who require specific interventions at primary mental-health care.

As my colleague mentioned earlier, we propose to develop an inpatient assessment centre for dementia services on the Mullinure site. Furthermore, we propose to co-locate all our community support and rehabilitation services for dementia alongside the inpatient service and develop a resource centre. Through that, we will offer an increased range of services and therapies specifically for memory services, support behavioural services, and so on, which I am sure that the Committee will agree are important and extremely necessary for that client group.

To assist with the proposals, there was significant investment in mental-health services and

disability services in the Southern Trust between 2006 and 2008. Some initiatives focus on the stepped care model, which is outlined in the Change in Mind project and takes a graduated approach to the delivery of mental-health services. As I said, it is delivered by three core teams: primary mental-health care teams; teams that tackle acute mental illness; and support and recovery teams. Significant investment in the development of community mental-health services and disability teams complements those three core teams, supports early recovery from illness and promotes rehabilitation.

Moreover, we have made significant developments in our home treatment and crisis response services, which focus on getting people out of hospital more quickly and stopping people from coming into hospital. The population is telling us that it would rather be cared for at home than in hospital. We have recently made some investment in home treatment and crisis response services for people who are over 65 years of age. We have opened new resource centres on the Armagh and Dungannon site and on the Craigavon site, which offer a range of therapies and interventions on an outpatient and sessional basis. They have enabled people to avail themselves of such services in the community instead of attending hospital.

One significant development in the Southern Trust is that our new model of mental-health service delivery has created a single point of access to all mental-health services. Highly skilled and trained staff triage all referrals through that single point of access to one of the three core teams that I described earlier. Alongside that, we are working with our voluntary sector colleagues to promote health and well-being and to ask them to deliver some services that focus on preventative work, such as anxiety management, stress management, counselling, and so forth.

There is planned further investment of £6 million by 2011 that will major on independent living, which is the further development of community teams to support our patients and clients in the community, with the future development of mental health and learning disability supported living facilities. We have already done much of that in the Southern Trust, and we propose to create other supported living facilities in mental health and learning disability that will enable people to live as independently as they possibly can in the community. We have put much investment into primary care services to focus psychotherapy and cognitive behavioural therapy (CBT) services at primary care level because that has proven to have stopped people becoming progressively more mentally ill.

Last, but certainly not least, we have opened a new resource centre alongside our state-of-the-art, award-winning psychiatric inpatient Bluestone unit in the trust. Community teams are co-located there, and the proposal is to build a new part onto the Bluestone unit so that all our mental-health services will be centralised on that site and will be delivered by highly skilled and trained staff. It also has the good fortune of being sited beside the acute hospital for the other needs of mental-health patients. We offer a range of effective therapies that are delivered through integrated teams, working in and out of the hospital across communities. We believe that that is the way to go for the future.

Mrs McAlinden:

Our children and young people's programme extends across all areas of care. We previously presented to the Committee changes to our residential sector, which are progressing. In relation to our service redesign, we have our Changing for Children strategy, which focuses on neonatal and paediatric services across the Southern Trust. That will bring some exciting changes and quality improvements to the service. We have plans to extend and redesign acute hospital care and to bring in new ways of treatment and new patient pathways.

Income generation is also part of our plan. We give examples in the briefing paper, particularly on cost recovery for car parking at hospitals. That has already started at Craigavon Area Hospital and has been well received by the people who use it, despite the negative publicity that we attracted.

We have plans to deliver £16·3 million of our target by the end of March 2010. Beyond that, we have firm plans to achieve £22 million of our target. We have a gap in our plan of around £13 million, which is our continuing focus on efficiency and productivity. Those plans include ongoing service redesign to meet changing needs, the Releasing Time to Care initiative, which is about productive practice for our professionals. We have productive wards already in place and piloted on a number of our sites, and we will move that across the range of services. We will continue to explore the skills mix because that is another way in which we can release professional time. We are learning about new technologies and best practice from exemplar sites across the NHS.

I emphasise that stable partnerships with the voluntary sector are vital to those targets. There is ongoing engagement, and some of those discussions are very difficult. We are talking about a

complementary service and not a duplication of service, but it is a positive and ongoing discussion. We have to improve the demand management whereby people access our system.

We began the year knowing that we would have some in-year difficulties. We estimated those to be in the region of £6 million. From 1 April, we had plans in place to address that internally. There are some additional pressures that have come on the trust. My Belfast Trust colleagues already referred to those, so I will not repeat them.

Our in-year contingency plan covers four main areas of work. Payroll is subject to cost control. We have cost control for goods and services. Unfortunately, that means that we must limit training opportunities for our staff and defer the purchase of equipment and a minor work schedule. All those measures are in-year ways in which to manage our budget.

However, the key message that I want to give the Committee to reassure members is that our first point of call is the protection of front-line services. We have deliberately taken decisions to manage in-year difficulties in a way that will not affect front line services. Therefore, the issues that affect the timing and delivery of our savings include the need for positive and real consultation and engagement for users and staff, and management of the impact on staff: it takes time to talk staff through their options for redeployment and other alternatives.

We need to work more closely with the Housing Executive on access to Supporting People funds, particularly the revenue strand. The availability and timeliness of capital funding is critical for the management of our change process.

Therefore, achievement of our efficiency targets is proving to be extremely challenging. The demand for our services continues to increase and is changing. That demand is not always followed by funding. We need to invest to change to new models of care. We are in the process of managed change, which takes time to do properly. Funding decisions create some short-term in-year pain. We must manage those pressures in a way that is coherent to our local population and staff.

The Chairperson:
Thank you, Mrs McAlinden. You may have heard my being mauled by a member of the media this morning. I made the point that the Southern Trust seems to have implemented its 3%

efficiency savings and kept fairly close — within 1% — to its budget without the angst, pain and histrionics that we see from other trusts. Is that an indication that, with proper planning, that can be done relatively painlessly and, as you have said, without much impact on front-line services? Is the Southern Trust showing how it is done?

Mrs McAlinden:

I would not dare to compare our trust with others. Certainly, there is something unique in the history of the Southern Trust. First, for between five and seven years, we have had strategic planning for the development of older people's services and acute services. That has resulted in the dramatic rationalisation of our hospital network. Therefore, we do not have the number of small hospitals that other trusts may have.

Secondly, with regard to capitation funding, we have, for a number of years, been underfunded for the size of the population in the Southern Trust area, which means that we have had to be more efficient. We have not benefited from the services that are in place in other areas. During the current CSR period, we have benefited from additional capitation services funding, which has allowed us to put in place some of the services that support our change programme.

Thirdly, as I mentioned at the start of my presentation, the benchmark efficiency measure that the Department uses shows that we are the most efficient provider trust in Northern Ireland.

Mr Gardiner:

Hear, hear.

The Chairperson:

There is a bit of bias to my right.

Mr Gardiner:

Why not?

The Chairperson:

Indeed, I may feel the same. It is interesting that, even with efficiencies, a trust can live within its budget and achieve its efficiency targets. Is some of that not commensurate with your being given adequate capital funding? I shall wear my constituency hat, briefly. I am aware that £70

million needs to be spent on Daisy Hill Hospital. Clearly, that would lead to greater efficiency in the use of that building, which is, perhaps, the first or second major hospital in the trust's area. What would happen if capital funding for that and other projects did not come forward?

Mrs McAlinden:

As you rightly point out, our hospital network in the Southern Trust area is lean. Craigavon Area Hospital and Daisy Hill Hospital provide acute services. They are supported by the South Tyrone Hospital, which is a non-acute hospital. The failure of services in any of those facilities would be detrimental to our overall ability to provide services.

As you also rightly say, Daisy Hill Hospital has not seen investment for a considerable number of years. At present, we have a major plan with the Department. We realise that in the queue for funding, many facilities are in front of Daisy Hill Hospital. Given that scenario, we have been working with the Department for short-term funding. You may be aware that, in September, the Minister approved funding of £500,000 to improve the hospital's neonatology unit. We have plans to improve our paediatric service, which would mean that, outside the Royal Belfast Hospital for Sick Children, Daisy Hill Hospital will have the highest-quality paediatric service in Northern Ireland. That is the level of quality to which we aspire.

Therefore, capital funding is critical to our change programme. The changes in mental-health provision that Mr Rice mentioned are contingent on a £6 million development to the Bluestone unit to accommodate additional beds. The changes that we want to make in our hospital system are dependent on capital funding. We cannot ask our staff to provide the best quality of care if we do not equip them with the necessary training and facilities.

Mr McCallister:

The Southern Trust controls the area in which I receive healthcare, so it is encouraging that it is running efficiently.

Mairead, what percentage of your budget is spent on administration? Gillian, will we need a mix between domiciliary and residential care for our older people? As you will be aware, earlier this year, residential homes were a major concern for the Committee and the communities that they serve.

Mrs McAlinden:

There is not a huge differential in the management costs of any of the trusts in Northern Ireland. My colleague William McKee said that management costs comprise 4% of the Belfast Trust's budget. Management costs make up 4·2% of our budget, and they are part of our audited costs.

Dr Rankin:

It is clear that, for the foreseeable future, we will continue to need access to residential care. That is not in dispute, and we will continue to provide residential care through our five homes and continue to commission care in residential homes in the independent sector. However, we recognise that more people are seeking to stay at home for longer before they need to go into residential care homes. That trend is reflected by empty beds. Our consultation is enabling us to reduce our staffing in line with the number of occupied beds, which means that we will be able to make savings and still provide the right level of access to residential care.

The investment profile from the Southern Trust over recent years, and this year, is a continuing investment in domiciliary care. We continue to provide care at home, often in complex circumstances, four times a day — and sometimes more — seven days a week. For example, we provide night-sits for people with dementia in cases where there are behavioural disturbances. In such cases, families cannot provide support seven nights a week, so we work in partnership with them. Therefore, there are extensive home-care packages that are right for people at a particular stage in life.

Our elderly population is growing, and there is a predicted growth of up to 25% over the next four years in the number of people aged over 85. Therefore, we need continued investment. That pattern of investment has been very visible in the Southern Trust area and is continuing.

Mr McCallister:

Did the Southern Trust inherit any deficit from the legacy trusts? If so, how much was that deficit? It is encouraging that the Southern Trust is meeting its targets for the resettlement of those with mental-health problems, and I wish you well in continuing that work.

Mrs McAlinden:

We have been working with both the Department and the commissioner on the inherited deficit from the legacy trusts. When we opened our books on 1 April 2009, we had reduced that deficit

to £4 million. We hope to continue to work with the Department and the commissioner, along with our internal efficiency programme, to stabilise that position over the coming year.

However, as I said at the beginning, new and increasing demands on our services emerge each year. For example, this year we had to stabilise our doctors' rotas because of the European working time directive. Consequently, the trust had to find a substantial amount of recurring funding to stabilise those rotas and ensure that we continued to provide services in Daisy Hill Hospital, Craigavon Area Hospital and other places. Therefore, given underlying and unfunded pressures, it is a movable feast.

Mr Gardiner:

I express my gratitude and thanks to the staff of the Southern Trust, particularly those who operate in the main hospitals in my constituency, for the high standard of care and treatment that they provide.

The Chairperson:

We will see that in next week's 'Lurgan Mail'.

Mr Gardiner:

I do not run to the 'Lurgan Mail' with stupid things like that. I am very serious; I am offering a personal thank-you to the people who deserve it.

Mr Rice, will you elaborate on how you plan to facilitate independent living?

Mr Rice:

There are two main approaches for what we intend to do with independent living. We intend to develop supported living accommodation through the resettlement process. We have worked with the Housing Executive to construct new state-of-the-art buildings to provide accommodation to reintegrate people into the community. Those buildings will provide between six and 10 units. That type of facility will be provided throughout the Southern Trust area. If a patient comes from a certain area in the trust, we will try to resettle them into that area. We have been operating that programme for some time and hope to continue it.

We also propose to increase the number of community staff who support our patients and clients to live independently in the community. They provide a range of therapies and interventions to enable the person to live in, and reintegrate into, the community, and to provide care and support to that person if he or she becomes ill. They will also focus on the rehabilitation needs that some people will have for a continuing period so that we can promote as much independence as possible in the community. However, it must be accepted that, for some of our patients and clients, it will not be full independence. We will have to provide other services such as day care, a resource centre or a day hospital that facilitates their living in the community. It is about offering a range of services and facilities to help those people to live in their own homes, with their own front door, and not to have to live in hospital.

Mrs McAlinden:

I will add to the comments about the Supporting People strategy, which has been immensely successful in enabling resettlement. The partnership with the Housing Executive has been critical. The Housing Executive's capital funding stream and revenue support needed to help people to maintain their homes has also been critical, but we are aware of, and concerned about, the limitations on the revenue stream of that budget. I think that that is the issue to which Mr Gardiner referred.

Mr Gardiner:

Therefore, if I wish to represent an individual in my constituency, I should take up the issue with the Housing Executive to get better co-operation in that field. Thank you, Mr Rice, for your prompt and explicit reply.

During my time as an MLA and as a councillor, I have received only two minor complaints about care. That speaks volumes about the standard of care and treatment, and the way in which people are looked after in the Craigavon area in particular. Again, I thank you all.

The Chairperson:

I concur; it is the same case with Daisy Hill Hospital. I very rarely receive any complaints; well done.

Mr Easton:

Your efficiency proposals seem to be much better than those from other trusts. Perhaps some of

those trusts might want to consider your proposals to see what the Southern Trust is doing that is a little less painful. I congratulate you on what you have done thus far.

Are you reducing the number of nursing staff?

Mr Rice:

No.

Mr Easton:

Therefore, that will not happen. Will you fill any and all nursing staff vacancies? Will those numbers be reduced by the back door?

Mr Rice:

No.

Mr Easton:

Therefore, the number of nurses will be left as is.

Mrs McAlinden:

The impact of the changes, and the extra investment for new services in the Southern Trust, means that we have a net increase of six nursing posts. That is not to say that, when nurses are asked to change what they are doing, they do not find it extremely challenging. In some cases, nurses decide that they do not want to make that change and prefer to take the option of early retirement or voluntary redundancy. Some decisions that have been made through the reform process have been extremely challenging. For example, the decisions on Mullinure Hospital and some of our statutory homes, the new ways in which we are providing services and the reconfiguration of the wards in Craigavon Area Hospital and Daisy Hill Hospital have all been extremely challenging for staff.

I am really proud of the way in which staff have moved with the trust because they have seen that the situation has changed for the better. It has taken some time to persuade staff of that; however, the staff who have been persuaded have demonstrated a real commitment to providing high-quality care. I cannot speak highly enough of the support that we have had from our clinical colleagues for the process.

Mr Easton:

We heard earlier that the Belfast Trust intends to cut agency staff. What is the Southern Trust doing about agency staff?

Mrs McAlinden:

As part of our in-year plan to manage our finances, we are targeting agency staff. There is a slightly different arrangement in the Southern Trust in that our bank staff does not have a time limit. It is a flexible arrangement whereby we can ask staff to fill shifts across a 24-hour period. In some cases, the nurses who are part of our bank do not always have the skills that we require; for example, for paediatric and intensive care nursing, we sometimes have to use agency staff. With pressure on our services, particularly at this point in time, the bank nurse facility does not always give us the capacity that we need. However, as part of our management effort to manage our finances in-year, the use of agency staff has been, and will continue to be, scrutinised and, where possible, minimised.

Mr Easton:

However, it is not a zero cut?

Mrs McAlinden:

It is not a zero cut.

Mr Easton:

Some trusts are putting their second set of efficiency proposals to the Minister. Are your efficiency proposals currently with the Minister, or have they been agreed?

Mrs McAlinden:

When you say our "second set of efficiency proposals", I assume that you are referring to the gap of £13 million for which we do not yet have firm plans in place. We are continuing to work with our staff to develop those proposals. If the proposals require significant changes to front-line services, we will certainly work with the Minister and departmental officials. We are exploring every option for increased efficiencies that will not be seen by the man in the street.

Mr Easton:

Have your efficiency proposals to date been agreed?

Mrs McAlinden:

Yes, they have.

Dr Deeny:

I welcome you all, and I commend you on your presentation, which was excellent. Some years ago, I worked in Daisy Hill Hospital, so the standards were always good down there.

I commend you on your rapid access clinics for elderly people. That is an excellent service, and I would like to see it rolled out across the trusts so that elderly people can be seen within three days. GPs do not want people being admitted unnecessarily to hospital. It is preferable that they be seen by a consultant and quickly receive that secondary care input.

Francis talked about crisis response. Perhaps you could clarify some points for me. You talked about further improvements for people aged over 65. Is that only in mental-health issues?

Mr Rice:

Yes, it is. The developments in that area are through the creation of six additional posts to focus on people aged over 65 with functional mental illness.

Dr Deeny:

My concern as a clinician is about capacity. That is the only concern that I have. I am well aware of the increasing number of patients who use Craigavon Area Hospital, following the closure of hospitals in Tyrone. Indeed, many of us thought that Craigavon hospital was for the population of Armagh, but it is now looking after a significant proportion of the population of Tyrone. It has often been said that Craigavon Area Hospital is stuffed. I have heard staff describe being run off their feet. A patient in the maternity unit told me that the midwives are very good but that they are running from one patient to another. That concerns me.

What is the waiting time in A&E? In maternity services, how many deliveries a year are there? I know that annual deliveries have risen significantly. Bed occupancy is a big issue. The frequent joke is that bed occupancy of more than 90% becomes dangerous to patients, who are

warned against spending too long using the toilet in case their bed is taken while they are away from it. On a serious note, what is your bed occupancy? Is it reaching levels at which hygiene is compromised, and hospital infections are more likely? My questions concern those three areas: accident and emergency, maternity and bed occupancy.

Mrs McAlinden:

I thank Dr Deeny for the opportunity to address those concerns and public perceptions. There is no doubt that Craigavon Area Hospital is busy and serves a wide catchment area, but it is a very good hospital. Its accident and emergency department is the busiest in Northern Ireland: more people come through its doors than any other such unit. Month to month, 94% of those people are seen within four hours. The department has been restructured and strengthened. We have increased the number of hours that senior doctors spend treating patients. We have invested in that approach because it was identified as a difficulty; accident and emergency is the route by which people present for treatment and judge a hospital's performance. I commend my A&E colleagues for providing an excellent service.

Dr Deeny is right about our maternity services. Births at Craigavon Area Hospital have increased considerably because our catchment area has expanded, and the population of the Southern Trust area has increased. To deal with the increase in births, we have invested considerably in additional staff, including doctors. We have also maximised the use of our midwife-led unit, increasing the volume of births that it can manage from 600 to 900. An extensive programme of work costing £3·5 million is being carried out to improve delivery rooms and outpatient facilities in Craigavon Area Hospital's maternity unit. A similar £500,000 improvement programme was undertaken in Daisy Hill Hospital last year, which was well received by clinicians and women who used the unit.

Your third concern was bed occupancy, which we measure every day. Dr Deeny is right; the bed occupancy in Craigavon Area Hospital is around 90% to 95%. We have managed that demand by ensuring that people come in on the morning of their surgery. In my presentation, I explained what we have done in that regard. We do not keep people as inpatients if they can be treated through day-case surgery. We have not only met the Minister's targets to reduce infection rates but exceeded them. Craigavon Area Hospital and Daisy Hill Hospital are extremely clean and safe hospitals.

Dr Deeny:

Considering how busy those hospitals are, is staff morale still good?

Mrs McAlinden:

Staff are extremely busy; we have set up forums at which we can listen and respond to their concerns. For example, the maternity department has a monthly staff forum that is open; staff can meet the director of acute services and senior management, they can express their concerns, and an action plan from each of those meetings shows staff how we, as an organisation, are responding to the issues that they raise. That type of arrangement, which often involves our trade union colleagues, is in place across every programme of care in the trust.

Mrs I Robinson:

Your answer brings to mind the old adage that a society can be judged by the way in which it treats its elderly people and its children. Mrs McAlinden's description of the Southern Trust's services has gone an amazingly long way to assure me, as an elected representative, that all that can be done is being done to treat our elderly population and our children.

I had the pleasure of seeing the mental-health facility at Craigavon Area Hospital. It is awesome, and I wish that its model could be rolled out across Northern Ireland. It is a breath of fresh air just to hear how pragmatic and focused the Southern Trust is in dealing with its budget. The attitude is not one of giving up trying to work within that budget by increasing cost-effectiveness. All I can say is that I congratulate you on your proactive and forward thinking.

I must declare an interest. My 89-year-old mother lives in a sheltered dwelling in Portadown, and it has been necessary for her to use Craigavon Area Hospital and Lurgan Hospital. She also receives care at home four times a day. She is as sharp as a tack, and I am delighted that she does not suffer from any form of dementia. By and large, her care is very good. The only thing that she sometimes complains about is the change of faces. However, I cannot complain about the regularity of her care, and, on her behalf, I thank you for that.

One area about which I have some concern is that, when my mother was in Lurgan Hospital, I noticed that she had been placed in a large mixed-gender unit. Are there any plans in the pipeline to improve that facility and do away with mixed wards?

Mrs McAlinden:

I shall begin to answer your question, Mrs Robinson, and I will then pass to my colleague. Our five-year strategy for Lurgan Hospital has secured the future of that facility, which is critical to how we manage the flow through Craigavon Area Hospital. Lurgan Hospital is one of our oldest facilities, and you are quite right that it could certainly do with being refurbished and improved. Some fairly inexpensive plans are in place; however, I must emphasise that we are in a queue for capital money. Using the resources that are available to us, we have moved to improve infection control and the privacy and dignity of patients. My colleague Dr Rankin will provide some details.

Dr Rankin:

You have raised an important issue, and we have done what we can with limited capital resources to improve the clinical environment for patients and staff. Nevertheless, a fundamental review of ward accommodation is required. Given the facilities that we have, we maximise the use of single and side wards for people with infections and for those who are terminally ill and need that privacy and dignity. In addition, the hospital operates a segregated gender policy, whereby we try to keep side and smaller wards for the gender for which we have smaller numbers. It is not always possible to have complete separation, but we work carefully to ensure that patients have privacy and dignity. Although we have a clear policy that we seek to implement daily, we do not have wards that are exclusively for men or women.

The Chairperson:

I notice that Mr McNally has got away scot-free. I think that his policy has been to keep his head down in the hope that no one notices. However, I want to ask him a couple of financial questions. The break-even legislation means that trusts cannot carry forward a deficit into the next financial year, and today we have seen the problems that that can cause. The Belfast Trust and the Southern Trust had to pay off debts that they inherited from previous groups of trusts. From an accounting point of view, does the fact that there is no way around the financial-year-end cut-off cause many difficulties?

Mr Stephen McNally (Southern Health and Social Care Trust):

It causes difficulties insomuch as our strategy for dealing with our financial situation, as set out by the chief executive, is, first, to find the right solutions for patients and, subsequently, to deliver efficiencies. Inevitably, our plans straddle financial years, so it would be better if we were able to

run a small deficit in one year in the knowledge that we could generate the required savings in the following year. Consequently, we could break even over a two- or three-year period instead of constantly trying to deliver a balanced position within a 12-month period.

The Chairperson:

I mentioned the large expenditure that is required at Daisy Hill Hospital, and there is a similar issue with Supporting People funding. There are concerns about the fact that 256 people in Northern Ireland are in institutions such as Muckamore Abbey Hospital and Longstone Hospital. Pro rata with the rest of the UK, that figure should be much smaller. It equates to 333 people per million in Northern Ireland in that type of care. In England, the figure is some 15 people per million. The long-term aim is to try to reduce that figure. Will you then be stuck with the difficulty that the Department for Social Development (DSD) does not have the funding for supported housing to provide those individuals with proper care in the community?

Mr McNally:

Lack of funding is certainly a constraint on our ability to progress the resettlement strategy. Francis will talk about the scale of that issue.

Mr Rice:

According to our latest information, the difficulty is not with the capital elements of the Supporting People money. The difficulty lies with the revenue elements, and DSD has had that under review. We had hoped that, by now, we would have known much more about what was available, which would have allowed us to have progressed our schemes. That is causing us some difficulty, because, although the capital element is important for the building of accommodation, we need the revenue contribution to enable us to provide a holistic model of care in the community. From our current information, the revenue budget is constrained, and that may have an impact on what we are able to do in the future.

Dr Rankin:

That also impacts on our care of older people, who, equally, should have the opportunity to move to supported housing with care. In an excellent scheme in Banbridge called Spelga Mews, 12 older people live in Supporting People accommodation. We have plans for similar schemes across the geographical area, and we are in discussions with the Housing Executive. Our first priority is a scheme in the Kilkeel area.

The Chairperson:

I am all ears. Let it be built early.

Dr Rankin:

We are in discussions with the Housing Executive, and we are waiting for a housing association to be nominated to look at a supported housing development for older people in Kilkeel. A similar constraint will apply to the revenue funding for the housing component of the partnership between health and housing to provide a supported housing with care scheme for older people or people with a disability.

The Chairperson:

I wish that every success, being totally impartial.

Ms S Ramsey:

Thank you for your presentation. I apologise that I had to step out; I was dealing with other Committee business.

It is good to hear that the trust is delivering what the Minister and the Department has asked of it, rather than it being exempted. I know that there are issues of productivity and of increasing services for the community. I will make a flippant point: perhaps the Southern Trust should be contracted out to other trusts.

The Chairperson:

That has happened. Colm Donaghy now runs the Northern Trust.

Ms S Ramsey:

It is good to see a good man doing good business there. Perhaps some of the Southern Trust's policies should be contracted out.

In your profile, you say that you provide care. I assume that you do so to a population that is similar in size to the populations for which other trusts are responsible. Your funding, annual income and staffing levels are probably half those of other trusts. Will you make a general comment on that? The other trusts would make an argument, and I have to be fair by saying that

some of the other trusts provide regional services. However, the Southern Trust has a similar size of population and faces similar health inequalities and other issues with half the budget and the half the number of staff of other trusts.

Were any of the proposals or suggestions that you put to the Minister equality proofed?

Mrs McAlinden:

I reiterate that our strategy has not been free of pain. We have had detailed discussions with staff and local representatives. The impact was substantial in the Armagh area, and the consultation process was fairly fraught. It has not been a pain-free process. Even some of the internal decisions that we are making to change services by moving away from traditional ways of working have posed great difficulty for some staff. We continue to have those discussions with staff.

Areas of our approach to, and our policy for, our service are recognised as best practice. We have had visits from people from England and further afield to see what they could learn from our discharge arrangements.

In respect of the comparison with staff in the other trusts, the Southern Trust and the Western Trust are similar in size. We do not provide regional services per se. We are under a capitation formula and continue to be an underfunded population. That contributes to some of the differences that you can see between our profile and the other trusts' profiles.

The trust's Changing for the Better strategy and the key changes that were made as a result of that were covered by an overarching equality impact assessment (EQIA) arrangement and an individual EQIA for every proposal.

The Chairperson:

We have managed to make up some time — I wish to finish at 12.45 pm — so there is time for Mrs Robinson to ask one last question.

Mrs I Robinson:

My question centres on the mental health of the staff who care for the carers. Do people with a background in psychology and psychiatry specifically address any underlying problems that your

professionals might have? Is that something that you are doing? I know that the stresses and strains of the work can lead to mental-health issues, and I wondered whether you provide such a service.

Mrs McAlinden:

You are absolutely right about the need for the trust to provide an occupational health facility. We have a duty to our staff to look after their emotional and physical well-being. We have recently enhanced that service by bringing in a senior doctor to work in the occupational health department. Staff also have independent access to psychological therapies and other services, and, if they have back problems, there is a service to fast-track physio appointments for them. It is our duty to support staff so that they are fit to do the job that we are asking them to do. As regards further detail on that —

The Chairperson:

Excuse me, will whoever owns that mobile phone turn it off, please? The interference that it causes means that not a single word of what Mrs McAlinden has just said will have been recorded properly, and we need to get a complete transcript of this evidence session. I am sorry about that, Mrs McAlinden. The interference has now stopped, so that is good news.

Mrs McAlinden:

Francis may also want to comment on the occupational health service and on the facilities that are available to staff.

Mr Rice:

I manage psychology services for the Southern Trust, and, through the psychology service in the occupational health department, we provide sessions for staff who wish to avail themselves of psychology services for specific reasons.

As Mairead said, if people do not feel comfortable with that, there is an opportunity for them to use the psychology services in the other trust areas. There is a reciprocal arrangement whereby we also treat staff from other trust areas. The trust is well covered in respect of the psychological and other support services that we offer to address mental and physical health problems.

Mrs I Robinson:

I am delighted to hear that.

The Chairperson:

Thank you very much, ladies and gentlemen. That was extremely informative and helpful, and it will certainly assist the Committee in dealing with the dominant issues facing the Health Service at present, including CSR efficiency savings and deficits. I hope that the representatives from the other trusts will be as forthcoming as you have been.