Northern Ireland
Assembly

# COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

# OFFICIAL REPORT
(Hansard)

## Presentation from the Minister of Health, Social Services and Public Safety on Departmental Priorities for 2009-2010

15 October 2009

**NORTHERN IRELAND ASSEMBLY**

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# COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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## Presentation from the Minister of Health, Social Services and Public Safety on Departmental Priorities for 2009-2010

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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
Mrs Dolores Kelly
Mrs Claire McGill
Ms Sue Ramsey
Mrs Iris Robinson

**Witnesses:**

| | |
|---|---|
| Mr Michael McGimpsey | ) Minister of Health, Social Services and Public Safety |
| Dr Michael McBride | ) |
| Dr Andrew McCormick | ) Department of Health, Social Services and Public Safety |
| Ms Julie Thompson | ) |

**The Chairperson (Mr Wells):**

Minister, you and your team are very welcome. Indeed, the A team of all the Department's top officials are with us today. Alongside the Minister are Michael McBride, the Chief Medical Officer; Andrew McCormick, the permanent secretary; and Julie Thompson, the director of finance. I invite the delegation to make some opening comments, after which I am certain that

members will want to ask questions. This session is concerned with the priorities for 2009-2010.

**The Minister of Health, Social Services and Public Safety (Mr McGimpsey):** Thank you very much, Chair. I am glad to see you sitting where you are sitting, and I congratulate you on your recent appointment to the position. As you indicated, I have brought my top team; only the best for you and the Committee.

The Committee will already be aware of the many challenges that face the health and social care service. Like me, I know that you have been impressed and humbled by the tireless work and commitment of staff across the health and social care sector to deliver a first-class service to everyone. From knocking on doors and holding clinics in your constituencies, you will be only too aware that health and social care affects every man, woman and child in this country. It is the number one priority for the public here, irrespective of what the Executive decided in their Programme for Government.

Every year, our Health Service treats around 500,000 inpatients, almost 1·3 million outpatients and 685,000 A&E attendees. Some 200,000 GP and nurse consultations are carried out every week. A mammoth job is undertaken with great skill and dedication by those who work in health and social care. I take this opportunity to express my personal thanks to, and admiration for, health and social care staff, who undertake lifesaving and life-changing business every day. Their task is not made any easier by the very challenging efficiency savings that have been imposed during the comprehensive spending review period. As if that were not enough, we face a worldwide swine flu pandemic.

Since the outbreak of swine flu, I have tried to ensure that the Assembly, the Committee and the Executive have been kept informed and updated about developments. I, and those working directly on the pandemic, appreciate the widespread support of the Committee and of other MLAs for what we are doing to counter and treat the swine flu threat. The swine flu pandemic began in Mexico on 24 April 2009, and the first case in Northern Ireland was confirmed in May. Since then, Northern Ireland has had 565 laboratory-confirmed cases of swine flu, a total of 280 hospitalisations and 12 intensive-care-unit admissions. Some 13,122 antivirals have been issued; eight school outbreaks have been reported since September; and, sadly, there have been four swine-flu-related deaths.

We are now in the second wave of the swine flu pandemic. There has been an associated increase in the estimated number of swine flu cases, laboratory-confirmed cases and hospitalisations and in GP and out-of-hours consultation rates. Swine flu levels continue to be much higher in Northern Ireland than in the rest of the UK, and, indeed, they are at the highest rate ever recorded in Northern Ireland. Recently, there was a 61% increase in the number of swine flu hospitalisations. Infections are generally mild, but some people will experience more severe symptoms.

The swine flu vaccine is key to preventing the spread of the virus and protecting the population. I am pleased to inform the Committee that we are finalising plans for the swine flu vaccination programme for people in at-risk groups and front-line health and social care workers. We received our initial share of the pandemic vaccine this week — 11,000 doses — and we expect to receive more next week. In line with the rest of the UK, we aim to start vaccinating front-line health and social care workers on 21 October 2009. Vaccination of those in at-risk groups is expected to begin shortly after that date.

It is essential to start the programme at the earliest opportunity to protect the people who are most at risk. GPs will write to those groups to offer them the vaccine. The timescales are subject to vaccine supplies arriving on time, and, as supplies arrive, vaccination will be rolled out to all areas as quickly as possible. I will urge all front-line health and social care staff and people in at-risk groups to take up the vaccination to protect themselves and others. Over the winter, vaccinations will significantly increase our resilience and help to save lives. It is still difficult to predict the course of the pandemic in the coming weeks and months. We can expect rises and falls in rates of flu, and there will be further waves. In previous pandemics, second and third waves were experienced between three and 12 months after the first wave. That is why it is essential that the public are vaccinated and protected against the virus.

We have been planning for the pandemic for several years, and we have taken every possible step to ensure that measures are in place to protect the people of Northern Ireland and reduce the potential impact of the virus. That costs money — some £64 million. This week, agreement was finally reached on funding for swine flu costs, and I welcome the contribution of other Departments. Despite reports to the contrary, my Department was not exempt from such contributions. Indeed, it has contributed £32 million, which is half of the total bill**.** Therefore, the total bill is £64 million, half of which is being paid by my Department. That was the only

way that I could get a deal.

I have also had to find a further £10 million from my capital budget to protect against existing services. Under the Budget deal, I am entitled to receive the first £20 million of available funds. To start that, and because we are so desperate for cash, I have taken £10 million out of my capital budget and converted it to revenue, with the Department of Finance and Personnel's (DFP) agreement. I am still waiting for the next £10 million, but I am pleased that the Executive have now described that first call as a priority.

Funding for health and social care services is still an issue of serious concern. When I met the Committee a little over a year ago, I set out the significant problems that lay ahead for my Department as it faced the dual challenge of achieving £700 million of efficiency savings and delivering £165 million in service developments. I remind members that the efficiency savings were decided by the Executive and voted on by Assembly Members on two occasions. I also remind members of the Assembly amendment that called for health to be exempt from the current round of efficiency savings. Sadly, that amendment fell, with only the Ulster Unionist Party and the PUP voting for it.

Members will be only too aware of the widespread public concerns that those efficiency proposals have raised. I have had to take difficult decisions about how care is delivered to the same high standards but with fewer resources. Failure to achieve the efficiencies will mean that planned service developments will not be met. That simply cannot happen.

I want to assure members that, despite suggestions that have been made in recent days — including some comments that have been made at this Committee — I have not allowed front-line services to be cut. In fact, the opposite is the case. I have ensured that money has been invested in those essential services. I will continue to make health and social services more efficient, and, under the review of public administration (RPA), the number of senior managers in health and social care has been cut by two thirds, and administrative posts have been reduced by 1,700. My Department is the only one that has not only met its timescales under the RPA process but exceeded them.

The calls for further cuts to administrative jobs continue, but, even if we were to take every single administrator and manager out of the system, it would still not fix the financial difficulties

that we face. In fact, it would place only an additional burden on nurses and doctors. Tinkering around the edges will not solve the problem, given the huge sums of money with which we are dealing. Efficient services are only part of the answer; the simple truth is that health and social care needs significant and increased resources each year to meet need, increased demand and improve quality.

That fact was affirmed by John Appleby in his report on the future of our Health Service, but it is one that has, regrettably, not been progressed. However much we argue about the figures, health and social care services in Northern Ireland are not as good as those in the rest of the UK. They cannot be, especially if we consider that, compared with England, Northern Ireland faces a funding gap that will widen to approximately £600 million by 2011. No matter how efficient we become, the sums simply do not add up. How can they, when I face demand rising at 9% per annum while funding grows by 0·5% above inflation?

In 2008-09, approximately 48,000 more people had a first outpatient appointment than in 2007-08. That had a knock-on effect on elective inpatients and day cases; we treated over 13,000 more people. In addition, 11,000 more people were admitted through A&E units for emergency inpatient care; coupled with that, there has been a 20% increase in birth rates since 2002, which continue to grow.

Over the next 50 years, the number of people who are over 65 years of age will more than double from almost 250,000 to 500,000. The number of people aged over-75 in our community is rising faster than any other age group, and, by 2050, it will be three times what it is today. It is important to remember that the cost of healthcare for people who are aged 75 and over is nearly four times greater than it is for the average citizen. For those people aged 85, it is nearly 10 times higher. I am sure that members will agree that those costs will have to be met if we are to ensure that our growing elderly population has access to the care that it needs.

Making our health and social care service more efficient is essential, and the Department is doing just that. Overall productivity is improving, and it increased by almost 7% in the past two years. New systems and processes have been introduced with great success, waiting times for surgery, diagnostics and outpatient appointments have reduced dramatically, and the Health Service is treating more people at home and in the community.

My question to the Committee, the Assembly and the Executive is: are we prepared to adequately fund the health and social care service? Everyone knows that there will be a hole in next year's Budget, so I am asking for the Committee's unanimous support in lobbying to ensure that the health budget will not be raided to bridge that gap. The facts are simple: if you are not prepared to fund the Health Service, there will be severe consequences, and there will be cuts. Those cuts will impact on our most vulnerable groups, especially elderly people who require more care and support than anyone else. Our health and social care staff are stretched to their limit in attempting to meet the additional demands, and they simply cannot stretch any further. Health is the number one priority for the public, because it affects every man, woman and child. It must be protected, but I cannot do that without the Committee's support.

More funding is required to drive forward the reform and modernisation of mental-health and learning-disability services, which are among my top priorities. The recommendations of the Bamford review are key to transforming those services. Good progress continues to be made, and there are many fine examples of that on the ground including some excellent mental-health and learning-disability facilities in Downpatrick, which I would urge the Committee to visit. The implementation of the Bamford review will be a long-term process and will require continued commitment across the Executive beyond the current CSR period. Funds from the CSR are being invested, as we speak, in the front-line services, as I outlined earlier.

I trust that what I have said today has given the Committee an idea of some of the major challenges in health and social care, what I am doing to tackle those challenges and the circumstances in which I must work. Health and social care is everyone's business, and it is too important to be used as a political football. I look to the Committee as fellow representatives of the people of Northern Ireland to support me in providing the very best healthcare possible for those people. The Committee has asked me for my priorities; those are my priorities.

**The Chairperson:**

Thank you, Minister. The Committee has certainly caught the drift of what you have said. You have made a very clear statement. Do any of the other members of the departmental delegation wish to say anything?

**The Minister of Health, Social Services and Public Safety:**

I should have introduced the people who are with me today. Andrew McCormick is the

permanent secretary in the Department of Health, Social Services and Public Safety, and Dr Michael McBride is the Chief Medical Officer, with whom the Committee will be familiar.

**The Chairperson:**

The Committee has already had the benefit of hearing from two trusts and of receiving written material from the others. From that evidence, it is quite striking that the Southern Trust has lived within its budget, achieved its efficiency savings and incurred a relatively modest deficit, while the Northern Trust seems to have been totally unable to meet its targets. Furthermore, there does not appear to be any great discrepancy between the trusts, which are suffering the same pressures equally. How can that be explained except by a lack of efficiency on the Northern Trust's behalf?

**The Minister of Health, Social Services and Public Safety:**

In the area of efficiency, a major change is that the Health Service in Northern Ireland has moved from 19 trusts to six. The Northern Trust is an amalgamation of five legacy trusts, and the Southern Trust is an amalgamation of three. That resulted in a cost differential, because it is more expensive to bring five organisations into one than it is to bring three into one.

The Southern Trust has benefited from capitation, which is the weighted formula through which the Department equitably delivers the health budget throughout Northern Ireland. Furthermore, its population is rising, which attracts a rising budget. The Southern Trust has also progressed further with its rationalisation of services, and, although, the Northern Trust has a number of units that deliver acute services, the Southern Trust, with one major acute hospital in Craigavon and a lesser acute hospital in Newry, are well on the way to rationalising its services, specialising and delivering. On the other hand, the Northern Trust delivers acute services from several sites. As you will see from the consultation and the CSR proposals, the Northern Trust is moving towards a more rational delivery of services. That explains the difference between the two trusts.

Also, the Belfast Trust was formed by merging five trusts into one, which was an expensive operation, and it was the main loser in capitation because of the amount of people who fled from the city. Even allowing for the weighted figures for the elderly population in the city, the Belfast Trust lost out through capitation. In addition, the Belfast Trust provides several regional services, such as the cancer centre and the children's hospital. Therefore, it has an added burden.

There are discrepancies between the trusts, but they are minor compared with the overall total. Given that the Belfast Trust's turnover is £1,000 million and the Southern Trust's turnover is approximately £450 million, the rises and falls are small. The Department is not allowed to overspend; its expenditure spend must be exactly on the line, and the accuracy of the trusts' spend has been commendable.

I have outlined only some of the problems that we face.

**The Chairperson:**

The Southern Trust also highlighted the rigidity of having to balance its finances by the end of the financial year. Given that some health programmes are long term and can take several years to implement, that must cause some difficulties. You could be spending money in one financial year to save money in the incoming year. Was such rigidity a departmental decision, or was it imposed?

**The Minister of Health, Social Services and Public Safety:**

It is entirely the decision of the Department of Finance and Personnel. DFP insists that we cannot overspend, we cannot keep reserves, and we cannot borrow from next year's money. Those are the rules. Earlier today, you heard from William McKee, whose job it is to deliver a £1,000 million budget. He must spend all of that money. If he were to spend £1,001 million, he would get into trouble.

We do not want to underspend. My Department's performance on spend is the best of all Departments. We are ahead of everyone else on revenue spend and capital spend. We do not underspend; we do not overspend. My Department is the most accurate. Even allowing for that and the careful management of the resource, the rules are extremely constraining. Anyone who has a business with a turnover of £1 billion finds it simple to borrow a bit of money from the bank, take some from the cash reserves or lift a certain amount from next year's budget. None of those options is available to the Health Service, and that is a major disadvantage of the particular and peculiar way in which Government finances are organised.

**The Chairperson:**

The trusts assumed that they would receive money from the savings made through the centralisation of procurement. Centralisation would have meant that all the trusts combined to

buy essential items such as medicines, and so forth, from one central source. The delay in the implementation of centralised procurement has caused each trust some financial difficulties. What is the problem? Why is that not up and running? How much slippage is there in its implementation?

**The Minister of Health, Social Services and Public Safety:**

As part of the review of public administration, the number of trusts reduced from 19 to six, and the four boards became one. The Department set up the Public Health Agency, and it established the Business Services Organisation to streamline those health functions that are not front line, such as procurement, IT, resources, HR and payroll. That process is ongoing. The better buying of drugs, for example, makes a large contribution to the Department's efficiency savings. The reduction in the drugs budget has been a major success. I will pass to Julie to explain the current procurement situation.

**Ms Julie Thompson (Department of Health, Social Services and Public Safety):**

At this point, the amount that has been delayed for 2009-2010 is £4 million. The trusts have been asked to take that into account and to consider how to make savings in other areas of procurement. The trusts have to recoup that £4 million, and that is their focus in considering how to buy more efficiently.

**The Chairperson:**

It is a significant element that the trusts were £4 million to £6 million overdrawn; they have kept their budgets quite tight.

**Ms Thompson:**

Absolutely. However, against the entire spectrum of what they are trying to achieve, they are trying to recoup the amount of £4 million. As with any scheme, if it does not produce at the level that was predicted, a trust needs to consider where else it can access other savings.

**The Chairperson:**

If it is not the trusts' fault that central procurement has not been implemented, surely it is unfair to expect them to build that efficiency saving into their budget and then to penalise them when the efficiency cannot be delivered because it has not been delivered centrally.

**The Minister of Health, Social Services and Public Safety:**

It is unfair to build £700 million of efficiencies into the health budget in total; I agree with you.

**The Chairperson:**

However, that is particularly unfair, because it is not the trusts' fault that central procurement has not been implemented.

**The Minister of Health, Social Services and Public Safety:**

The whole thing is unfair.

**The Chairperson:**

We will move on to a different issue, which many members wish to comment on, which is the 256 long-term patients in places such as Muckamore Abbey Hospital and Longstone Hospital. We know that the reason why many of those patients are not in the community is partly a lack of funding from the Department for Social Development (DSD) for supported housing. How much effort is the Department making to deal with that issue and negotiate with DSD to try to resolve it? The Department of Health, Social Services and Public Safety is dependent on another Department to implement the construction and management of sheltered dwellings. Where do we stand with that? It is causing the trusts some difficulties.

**The Minister of Health, Social Services and Public Safety:**

When I became Minister two and a half years ago, I refocused the Department on the issue of resettling long-stay patients. We laid down certain targets, and we have achieved those. Those targets included ensuring that no child would have a hospital as a permanent address by 2009, and that no adult would have a hospital as a permanent address by 2013 or 2014. We also set down a range of performance targets for the number of patients to leave hospital and be resettled. That is what we are doing.

I want to mention a couple of issues. Individual patients need a great deal of acclimatisation to allow them to move out; it is not simply a matter of picking a date. At one stage, the number of long-stay patients was 1,000, and that figure has now been reduced to 256. The figure continues to fall, but many of the remaining patients have very complex conditions and will need major support in the community. The difficulty in obtaining finance for that support in the community — 24/7 care — is a constraint. The provision of supported living is constrained by

the housing budget, for example. Progress on supported living is being made in St Paul's Court in Lisburn, for example, and in Downpatrick. I believe that DSD has provided for that in its capital budget. Put simply: if everybody wanted to move out of long-stay hospitals tomorrow, the supported living provisions would not be in place to enable that.

**Mr Easton:**

Thank you for attending today, Minister. I was struck by the efficiency savings that have been made by the Southern Trust. I know that trusts cannot be compared with one another, but the Southern Trust seems to be on the ball in what it is trying to do. Although trusts cannot be compared like for like, is there anything that the Southern Trust is doing that other trusts could consider that might be helpful for their efficiency savings?

I have seen signs that the plan to abolish some 700 nursing positions may not now happen, or may not happen in full. Will you fill us in on exactly what is happening about that issue? The Belfast Trust is dealing with it by not filling vacancies, but we found out that other trusts may not be doing that. Will you update us on that issue?

I have always wanted the number of agency staff to be reduced, and we are seeing evidence of that happening. However, how do bank staff compare with agency staff? Are the costs similar? Which is cheaper? I would value your opinion on that.

I must give you credit for your actions on swine flu; you have done a good job. However, I wish to query your policy on vaccinations. You are providing vaccinations for everyone in Northern Ireland who wants one. Many people will choose not to be vaccinated. I am not a medical expert, but do we need a vaccination for everyone in Northern Ireland.? The take-up rate of seasonal flu vaccine is low; even a large proportion of health staff does not take it. Do we need to provide so many vaccinations?

How does Northern Ireland compare with the rest of the UK in productivity? The gap has closed, but we are still some way behind the UK.

**The Chairperson:**

That is enough questions for now.

**Mr Easton:**

May I have one last question, please? You mentioned efficiency savings, and you called for an exemption. You talk about not receiving political gain from that, but it is something that you represented as having been done by your party. Your Department gets all those efficiencies back, so even if it were exempt, it would not get that money back, and it would not be able to pay for many of the new services that it is providing. Are you providing too many new services and leaving short some of the services that are already in place?

**The Minister of Health, Social Services and Public Services:**

I will ask Michael McBride to talk about swine flu, because he is more able than I am to address that question. I will also bring in Julie and Andrew.

The notion behind efficiencies is that money is saved for investment in new services. That is the whole deal. It is about being more creative and inventive with money. Rather than spending money the way that it was always spent, it can be spent in new ways. That is what is supposed to happen. However, my budget is so constrained and underfunded that, of the £700 million in efficiency savings, I need to take £400 million to put back into the budget simply to keep the show on the road. There is only a small balance that we can use recurrently for new services. That reduces the margin.

Productivity is up almost 7%. In my opening remarks, I said that the Health Service is treating more and more people, demonstrating that, far from cutting front-line services, they are reinforced, and we are doing more work than we did previously.

We have the same number of nurses in the Health Service today as we had two and a half years ago, 18 months ago, one year ago, this time last year or the last time I was here. The number of nurses has remained constant. The issue concerned a reduction in the number of posts, not nurses. That reduction allowed us to pursue such issues as the use of agency nurses, which, although essential, is becoming too expensive. We have reduced the use of agency nurses, and we use bank nurses instead, who are nurses in the system who volunteer to do this type of work. That subtle blend ensures that we do not always run to outside agencies or the independent sector but manage in-house resources. As far as nurses are concerned, there is no change. When I accepted the trusts' proposals, I gave them a written instruction to have the right number of nurses in the right places at all times. I stated that I will not compromise on patient safety or

quality of care. The trusts follow that principle.

You spoke about the Southern Trust. All the chief executives share best practice. Mairead took over in the Southern Trust only in the summer, and she is doing an excellent job. Before that, her chief executive was Colm Donaghy, who is now chief executive of the Northern Trust. I have no doubt that the good practice that he put into place, and which Mairead carries on in the Southern Trust, will translate to the Northern Trust. The Committee will also have an opportunity to talk to Hugh McCaughey of the South Eastern Trust and Elaine Way of the Western Trust, just as you have talked to William McKee this morning. I have been in business for a lifetime, and I am not unimpressed by any of them. They are all top managers with top teams around them, doing a routinely difficult job in managing a huge resource. The only requirement for access to the Health Service in Northern Ireland, as in the rest of the UK, is that you are a citizen. That is the only requirement. Money does not change hands, and everyone who comes to the door is treated and has to be treated. That takes phenomenal planning and huge foresight throughout management and in all posts.

I think that I covered most points about swine flu in my presentation. If I have not, forgive me. Michael is best able to speak on that subject.

**Dr Michael McBride (Department of Health, Social Services and Public Safety):**
To answer Alex's specific question, we need to bear in mind that this is a novel virus. None of us, or very few of us, has ever encountered anything remotely similar to this virus. As with all new flu viruses, the subsequent course of the pandemic is very unpredictable. We do not know what lies ahead in the coming weeks and months, and the Minister has already spoken about the potential for further waves. The best way to protect the population from this novel strain is to implement a vaccination programme.

There has been a unified approach across the UK. In August, the four UK Health Ministers announced the initial priority groups that should receive the vaccine first. The strategy is to protect those at greatest risk of complications: those aged between six months and 65 in the seasonal at-risk group who have underlying health conditions; people over 65 years of age in the seasonal flu at-risk group; pregnant women; and carers for individuals who are immunocompromised.

The Ministers will continue to be guided by the Joint Committee on Vaccination and Immunisation (JCVI), which is advising all of us on the evidence base for the vaccination programme in light of evidence that shows how the virus is evolving, how the vaccine is being taken up and how effective it is. We are planning a similar approach on vaccine uptake across the UK. There will be no variation of approach, and we are rightly proud of the uptake rate for our normal seasonal flu vaccine, which is in excess of 75% of those who are offered the vaccine. That is among the best uptake rates in the UK.

I have no doubt that our front-line health and social care workers, as well as the general population, will respond to the offer of the flu vaccine to protect themselves, their families and carers, as they do each year. We have been working closely with all the professional bodies and unions to encourage healthcare workers to protect their patients by availing themselves of the opportunity to have the flu vaccine and to ensure the integrity of the service.

There is absolutely no doubt that there is significant flu activity. We have been recording figures on flu activity for nine years, and we have never witnessed the current levels of flu activity. As the Minister said, there has been a 61% increase in hospitalisations because of H1N1 recently. There is a tremendous risk of complacency with the significant public health threat that the virus still poses. We need to ensure that we communicate that message clearly and consistently to the public so that we protect the population from whatever lies ahead.

**Ms S Ramsey:**

I welcome the Minister and his team, and I thank them for appearing before the Committee. For the record, I do not think that anyone is in any doubt that the Health Service has been underfunded by successive British Governments for years. In saying that, I do not think that anyone is in any doubt that money has been wasted in the Health Service for a number of years through the issuing of contracts and private consultants being brought in. Although we are discussing efficiency savings, we are also talking about streamlining services in the health sector so that our people get the best possible care.

I am heartened by the fact that, every time the Minister makes a statement, either in the Assembly or to the media, he states that he will not allow front-line services to be cut. The Committee has been told by a number of witnesses today that there will be no cuts to front-line services. However, without being flippant, the Minister repeats that message, and the next thing

that the Committee hears in the media is that there is a proposal to cut 150 beds here, nursing staff there and that new mothers will be discharged six to nine hours after giving birth. Part of me believes that the Minister is solid on not allowing front-line services to be cut. However, the trusts come along with proposals that, to my understanding — unless I am on some sort of cheap generic drug that has me all over the place — constitute cuts to front-line services.

The Minister and his Department's letter to the trusts state that its proposals would be allowed:

"conditional on your assurances that the quality of services for patients and clients will be maintained or improved, and that Priority for Action targets and commitments will be delivered".

Will those targets and commitments be delivered? Will the Investing for Health strategy be delivered? Will the Programme for Government commitments be delivered? I doubt that that will happen. In parallel, will we see an increase, perhaps not in front-line care being targeted, but in waiting lists? Will waiting lists grow bigger in primary and acute care?

Earlier, in reply to a question from the Chairperson, the Minister warned that somebody who goes over their budget gets into trouble. That leads me to ask whether that includes debt that has been incurred from the legacy trusts, which the Committee discussed this morning. The Belfast Trust alone inherited a debt of £30 million. Have the Minister or his Department, or the previous Health Administration, done anything to make the chief executive accountable for those debts? I know that people received a substantial pay-off when the trusts were amalgamated, but there is a £30 million debt in the Belfast Trust alone, and it is important that someone is held accountable for that.

I am glad to see Andrew McCormick back at the Committee. Does he think that DFP is committed and that it believes that all Departments can deliver their efficiency savings? If DFP, for which Mr McCormick worked at that time, believed that the savings were possible, why, now that he is DHSSPS official, do you believe that the same savings are not possible? All that I want is information, because I want to convince the public that there is an issue, that there is underfunding but that there is also proper maintenance and management of the budget.

**The Chairperson:**

The Committee cannot ask questions about an official's role in a previous Department.

**Ms S Ramsey:**

My question is relevant.

**The Chairperson:**

The official is entirely at liberty not to answer such a question, for very good practical reasons. We cannot go back into history by questioning somebody about their previous role. However, that is entirely a matter for the person concerned.

**The Minister of Health, Social Services and Public Safety:**

I will run through some of those questions, and then Andrew can talk about that issue. I could answer for DFP for him, but I will let him do so.

I have reduced the consultancy spend by 70% in the past two years. However, members should remember that consultancies are used for several issues from designing new hospitals and buildings to improving efficiency or ensuring that we follow DFP guidance. Consultancies involve more than simply offering opinions; they are absolutely essential. For example, we do not employ architects to sit around and wait to be given a commission to design the new Downe Hospital in Downpatrick; we must buy in that expertise.

The member is right to say that health suffered from serious underinvestment. This is not only a health issue. If we compare the situation here with that in England, as Alex did with efficiencies, it must be borne in mind that my Department manages health, social services and public safety. In England, Scotland and Wales, the equivalent Department manages only health.

Our budget for social services is running at more than £800 million; therefore, the Departments cannot be compared like for like. Thus, as far as efficiencies are concerned, we are rapidly closing the gap. The only applicable measure that Appleby used was one on acute hospitals. He made a number of recommendations, and we are implementing all of them: shorter stays in hospitals, more care in the community, more day cases, and so forth.

He also made a key recommendation that the health budget should receive a 4·3% uplift in real terms, year on year, to allow it to catch that in England. Although DFP agreed to it at that stage, it was never actioned. That is a reason — Andrew will talk about it — why we should consider efficiencies against those in other Departments. In a previous life, the Chairperson, Jim Wells, was Deputy Chairperson of the Committee for Regional Development, whose Department spent about £70 million on consultancies. We have spent a fraction of that, and, therefore, our

Department stands up to scrutiny reasonably well. The increase in the budget this year is 0·5% in real terms. The Committee should remember how I fought for budgets and who fought against me.

**Ms S Ramsey:**

I remember it well.

**The Minister of Health, Social Services and Public Safety:**

We eventually moved from the draft budget to our current budget, but we still received a 0·5% increase this year. According to Appleby, we should receive a 4·3% increase. The demand in health and social services in Northern Ireland has risen by almost 9%. The discrepancy in those figures demonstrates that services are stretched. At that rate, how can we maintain front line services indefinitely? The Health Service is working flat out, and health and social care staff are stretched because we are doing far more business with the same number of staff.

The Investing for Health strategy is part of the service developments. I argued for money from the Budget for service developments. Although most of it has been used to pay the bills, we retained and managed money for the Bamford review, which examined mental health and learning disability. We talked a bit about resettlement. The Investing for Health strategy is another key factor, and it is about pressing down on demand in the long term. We have set up a Public Health Agency; no other health service in the UK or on these islands has done that. The Committee strongly supported that measure, and I am grateful for that support. That is one way that we will attack future demand in the Health Service. It will be many years before we can prove its effectiveness through numbers, but it will attack health inequalities. Disadvantage, deprivation and educational disadvantage march hand in hand with health inequalities, unemployment, and so on.

You asked about the deficits in legacy trusts. We are where we are, and that is the situation that we inherited. The Administration in those days should probably have paid those off. However, they did not do so. Andrew, others and I made arguments with DFP that we deserved support. What happens if we do not have enough money to reduce waiting lists? Everybody knows what will happen: waiting lists will increase. Insufficient resource was put into health under direct rule, and Northern Ireland ended up with the longest waiting lists in the UK and among the longest in Europe because we de did not have the resource to address the need. I do

not want to return to those days.

Some of the consultancy money was spent on advice on how to move away from that situation. It took new ways of working and serious investment in the infrastructure to get away from that. We are now on the cusp, and we face a difficult future. I will ask Andrew to talk about the situation with DFP, because he is probably the most experienced civil servant in the system on finance issues.

**The Chairperson:**

No pressure there. *[Laughter.]*

**Ms S Ramsey:**

The gamekeeper becomes the poacher.

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

The Minister has consistently said that it is very difficult to deliver efficiency savings in the context of an insufficient increase in the total budget. Other parts of the UK have been dealing with the same 3% demand. Scotland reduced it to 2% in finding efficiency in its health services. It has the advantage of a better rate of growth. Delivering efficiency means making changes. Often, the only way to do that effectively is to spend first and benefit later; that is, the service is changed and money is invested in a new service that is more efficient and costs money up front but delivers long-term savings in due course.

It has been much more difficult for us to do that because the total budget available has been more restricted. That is a big difference. It is a change from what I remember of previous times. I do not comment on what DFP should or should not do at this stage, but, from our point of view, we have a very difficult task, and the trusts have stepped up to the plate to make it possible.

The context is as follows: there are differences across Northern Ireland about the issues the trusts face; different rates of growth of budget affect them because the distribution is changing; and there are differences in their starting points, as the Minister explained, in the distribution of services. All those issues make it challenging for the trusts to deliver. They are working hard to do that. They need recognition of those issues, support to deal with change where it is appropriate so that they can provide better services for the public. That is what we are all

working together to try to achieve. That is why the Minister seeks support in that task and a better recognition of the budgetary issues that we face. That is the way to put it. We need to recognise the need for health and social care expenditure. It was a big issue during my time in DFP, and it is a very big issue now.

**Mrs McGill:**

Thank you, Minister. You and your team are very welcome.

You mentioned mental health and learning disability among your priorities. I welcome the fact that those have become priorities for the Minister, the Department and the Committee. A constituency issue has been raised with me in the past day or two, and it may be associated with efficiency savings. In the learning-disability community, carers, parents and guardians in the Strabane District Council area are struggling. I want that on the record. We are all aware of the budgetary difficulties, and we know about the need for efficiencies. That issue was raised with me, and I do not know how it will be addressed.

Radiology provision at Tyrone County Hospital is also an issue. It was raised in the context of planned — or, perhaps, rumoured — proposals about what will happen to night-time radiology provision. I mention that because A&E has been removed from Tyrone County Hospital. Someone asked me whether the urgent care and treatment provision can be sustained there if night-time radiology provision is removed. The Minister's letter to the Chairperson of 8 October 2009, on the proposals from the trust on efficiency savings, states:

"Andrew McCormick's letter of 28 March 2008, which outlined that Minister's commitments concerning the Tyrone County should not be infringed by 2008/09 plans, continues to apply."

May I ask Andrew McCormick whether the urgent care and treatment on a 24/7 basis at the Tyrone County Hospital in Omagh will be protected?

**The Chairperson:**

We must be careful that we do not drift into detailed constituency issues.

**The Minister of Health, Social Services and Public Safety:**

I can address that. Tyrone County Hospital is an urgent care and treatment centre, and I do not see any threats to its future. We have an issue in the Western Trust about the recruitment of

doctors, particularly junior doctors. That is an issue in some of the hospitals. I have increased the number of training places in Queen's medical school by over 40%. It will be 2012 before that starts to have an effect. In the meantime, we are dealing well with the situation. We have also seen off other threats, but I see no problem with this. The urgent care and treatment centre will deal with most of the needs of that local community as far as non-acute services are concerned.

I have said that learning disability and mental-health care are my number one priorities. I am pleased to say that an action plan that is based on the Bamford review was cleared by the Executive some three weeks ago. The action plan requires all Departments to play a role: the Department of Education, the Department for Employment and Learning, the Department for Social Development, the Department of Finance and Personnel and the Office of the First Minister and deputy First Minster have key issues to address, and they will all have a role to play. A joint ministerial group is working to deliver the recommendations that were set out in the Bamford review, and that will take between 10 and 15 years to achieve. That is an area in which I have invested strongly.

Around half of the £200 million budget for mental health is being spent on psychiatric beds, and the Bamford review wants the Department to get away from that situation. The average stay of a patient in a psychiatric ward in Northern Ireland is between 36 and 38 days, which is far too long. Patients can come to harm during such stays, so, to reduce the length of stay, we need fewer beds and a different type of unit.

There have been new investments in the Bluestone psychiatric unit in Craigavon, the new hospital in Downpatrick and the proposed new hospital in Omagh. The issue is more about supporting people in the community. People with conditions such as depression, anxiety and addiction can be dealt with and given support in the community. That is why I am investing in community services.

That is also the case for learning-disability services. You said that services are being stretched, and I have already admitted that. The Department wants and needs more money. The transition from one service to another is difficult, as all transitions are. However, the Bamford review has laid down that we must go in that direction. This is not being driven by economics but by patient need.

**Mrs McGill:**

Chairman —

**The Chairperson:**

I hope that your question is not about Strabane?

**Mrs McGill:**

It is not; I wish to make a general point. I thank the Minister for his response. We all agree with what he said about the Bamford review and addressing issues in learning-disability and mental-health services. Although everyone has good intentions and wants all the recommendations to be implemented, even as we speak, the learning-disability community is struggling desperately to get that provision. However, I will take the Minister at his word.

**The Minister of Health, Social Services and Public Safety:**

My Department has invested in 200 new respite care places that will benefit around 800 users. I am reviewing the situation with respite care, because no one is clear about what exactly we are doing or where the need lies. The investment in learning-disability services has increased by £33 million to around £200 million, which is the same amount that is invested in mental-health services. We are investing in those services and are keen to push that agenda forward.

**Mr Gardiner:**

Thank you very much for your presentation. Your presentation, which was not a happy one, revealed the stress and strain on the Health Service because of the restrictions and shackles that have been placed on your Department. I am led to believe that there is a £370 million Executive funding shortfall. What effect will that have on your Department and on the services that it provides?

Furthermore, your Department has been directed by the Executive and the Assembly to find more than £700 million of efficiency savings in the next three years. That will certainly put the shackles on your Department and restrict it greatly. Is it time to revisit that so that the Department can be free from bargaining and the cuts that it suffers? When the Department suffers, the community suffers.

**The Minister of Health, Social Services and Public Safety:**

The paper about the need to cut £370 million of Executive spending is in the public domain. Those cuts are nothing to do with Gordon Brown or Westminster but are the result of problems in Northern Ireland. That is the current situation, and it is no secret that more cuts will come.

With respect to how one addresses that, the Chairperson had some handle on it this morning when he spoke about families who needed to reduce their expenditures by prioritising the feeding of their children and cutting out the annual family holiday. That re-prioritisation is the most important thing that Government can do, and spending on health is the equivalent of feeding the children, while spending in the other Departments is the equivalent of going on holiday. We must protect the health budget, because the Health Service saves lives and ensures that people are not in pain and distress.

There are many other functions in other Departments that are not as important as health. In an ideal world, all those functions of Government could be carried out, but we are not in an ideal world because of the budget shortfall. I ask the Committee to support me in ensuring that the health budget is not raided again as it was for swine flu, with the Department having to contribute 50% of the total cost. That represents a £32 million cut for areas other than swine flu, in addition to all the other cuts that I have spoken about today.

You cannot tax the sick to pay for the sick, and, as I said in my answer to Sue, if demand has increased by 9% and the budget for health has increased by only 0·5%, one does not need to be a genius to realise what the result will be.

Did you have another point, Sam?

**Mr Gardiner:**

My other question was about the £700 million that the Executive and the Assembly have directed the Department to save over the next three years. That will really put the shackles on you and your Department when trying to get the best for the people of Northern Ireland.

**The Minister of Health, Social Services and Public Safety:**

The situation with public finances is enormously difficult, and it is not finished yet. That is no secret. Departments are supposed to work out their projected position for the year ahead and plan

for it, and we will see how those plans begin to translate. However, what the Executive cannot do is go after the health budget in the hope that, because it is the largest, it will yield the greatest amount of money. That approach will cause the most pain and hurt. I put it to the Committee that that should not happen but that it could happen.

Last week, the Executive found £23 million to fund the CSeries project in Bombardier. I supported that project, and I proposed that the Executive would fund it and swine flu. That proposal presented difficulties for some parties, but, a few days later, it was announced that DFP had found £23 million of capital in a drawer somewhere to fund the CSeries project. We must be able to see the full picture. However, I am not currently seeing it, because I am not part of the magic DUP/Sinn Féin coalition.

**Ms S Ramsey:**
Thank God for that.

**Dr Deeny:**
The Minister is very welcome today, as are Andrew, Michael and Julie.

It is very beneficial that we are talking about this issue and what will happen with the health budget, but I want to focus on the community side of things. There is a fairly widespread mindset that community care is always the cheaper option, which, as we know, is not necessarily the case. The relocation of patients from institutional care to the community, the carrying out of more day procedures and early discharges after operations and from maternity wards are causing concern among community healthcare workers.

The Minister mentioned investment in the community; I want to see some evidence of that. I declare an interest as a GP, and GPs do not want to be overwhelmed. We need evidence that, in primary care projects, there will be investment in the community so that staff will not be completely swamped when they deal with people who have previously been dealt with in secondary care. The nurses, carers and doctors are up for that, but we need to have resources for personnel and facilities. That is very important.

Michael, we are aware of the potential gravity of the swine flu situation. You provided figures today, but none of us wants panic among the community. Many of my colleagues are aware of

the number of people being diagnosed with swine flu, but, as far as I am aware, we do not diagnose it in primary care: we treat in primary care. There may be one or two pilot practices, but, by and large, diagnoses are not being confirmed except for people who are ill enough to be admitted to hospital. We must be careful when stating the number of people with swine flu. There are many viruses that are not swine flu that can cause similar problems.

**The Chairperson:**

Dr Deeny, will you come to your question?

**Dr Deeny:**

Yes, I will. I am asking about diagnosis, which is important. We need to be accurate when stating the number of definite cases of swine flu, and we need to be accurate about diagnosis. Will you clarify the situation?

**Dr McBride:**

Kieran will be very familiar, when wearing his professional hat, with the ongoing monitoring for flu activity in the community. In Northern Ireland, we have been monitoring that robustly, as has the rest of the UK, for the past nine years. We track rates of consultation with GPs in daily and in out-of-hours practices and in a number of sentinel sites in primary care. That represents some 11% of the population across Northern Ireland.

We also moved on from contacting and swabbing all patients and potential contacts during the containment phase in July into clinical diagnoses. The clinical diagnosis of H1N1 is no different to the clinical diagnosis of seasonal flu that GPs and others working in primary care and hospital settings are familiar with. The mechanism that we use to monitor community transmission rate is the same one that we have been using for the past nine years.

There is a good evidence base that the rates of consultation with GPs, out-of-hours practices and the rates of prescribing of antivirals closely mirror the rate of flu activity. As we witness the rises in consultation and antiviral prescriptions, we have similarly witnessed a rise in the rates of positive samples that have been taken at those sentinel practices. We have a robust process in place, as there is a robust process across the UK.

We estimate that, since the outset of this pandemic, we have had some 11,000 to 25,000 cases

of H1N1 in Northern Ireland. We prescribed over 13,000 courses of antivirals, so there is significant community transmission of H1N1. We have never seen levels of transmission like this before. This week represents a significant increase compared with last week, but we must keep a sense of proportion and not create panic.

Our primary and secondary care services are responding well, and professionals are doing what they always do, which is to rise to the challenge. We are managing. I am confident that our planning over the past four years will put us in the best place to continue to protect the population; to prevent transmission through the public health campaign and the leaflet-drop from the Department and other bodies; to ensure that we protect those most at risk as the vaccination programme rolls out; and, on the basis of recommendation from the JCVI in due course, protect the wider population. We have a robust process in place.

I hope that I have answered the member's question.

**The Minister of Health, Social Services and Public Safety:**

Over the comprehensive spending review period, we are spending an additional £44 million on developing and improving community services for patients with long-term conditions such as stroke, diabetes, chest complaints, and so on. We are investing heavily in the infrastructure of primary care through health and care centres. Though the new commissioning process under the new Health and Social Care Board, GPs are driving each of those commissioning groups. I have placed an active, working GP as chairperson of the board, and, at the core of the commissioning groups, there are four local GPs. Therefore, primary care can drive the new process.

At the start of this process it was put to me by no less a person than Mary Hinds, who represented the Royal College of Nursing (RCN) in Northern Ireland, that our hospitals are filled with people who, had they made different lifestyle choices 20 or 30 years ago, would not be in hospital. We now hope to concentrate on the upstream. That also fits in with the view of the Wanless report, whereby we have to be efficient and have the proper resource, but we must also invest in the upstream of public health by persuading individuals to take more responsibility for their own health, so that in 20, 30 or 40 years' time, they do not end up in situations in which they need not necessarily be.

**Mrs I Robinson:**

A saying comes to mind: the Minister violates his principles quicker than he can lower his standards.

If one repeats a point or a figure often enough, it sticks in people's minds. In his typical fashion, the Minister bemoans the shortfalls in his budget, which all Ministers could do. However, because we are dealing with health, which affects everyone's lives, his crying foul of his Department's budget has an immediate impact on the public.

We should look at some facts. With much less money, the Department ran 19 trusts and four boards. Now we have six trusts and one board. Forty-eight per cent of the total block grant goes to health. That is the highest-ever budget to be given to addressing the health of our people. Unlike any other Minister, this Minister can plough any efficiency savings made back into his Department.

If the Minister had come here today with his sleeves rolled up, accepted his budget and got on with living within his means, I would have respected him. If he says that there are inefficiencies, why are the books not audited? One would think that the Minister was never involved in making his bid in the Executive. I recall that, after he got his top-up, he was very pleased with it. He has managed to line up the unions and certain chief executives to fight his battles on the media by deliberately picking areas of healthcare such as maternity, bed closures and cuts in nursing levels, which were calculated to energise the public's outcry and deliberately to deflect attention from his inability to cope with the budget. The Minister would be well advised to take on board how everyone from whom we have heard today, especially the representatives of the Southern Trust, manages within their budgets.

I ask two questions. First, what is the Minister doing to persuade the pharmaceutical companies to curtail the cost of drugs? What is he doing to influence the cost of drugs? Secondly, I know that the Minister has put his hands up and surrendered in terms of the Treasury coming forward with some moneys to help with the shortfall associated with the swine flu pandemic. I still believe that there will be help. Perhaps I am an optimist, but, at the same time, it is rather sad that our Minister has indicated his inability to make a case and come back with some good news from the mainland. I would like to have answers to those two points, if I may.

**The Minister of Health, Social Services and Public Safety:**

I will try to run through those points; we are on old ground.

I was as thrilled as anyone in the House at the beginning of September when Mrs Robinson told us that the Treasury was going to pay for swine flu. *[Interruption.]* My experience of it, if I could speak without being harassed, was that I asked the then Minister of Finance and Personnel, Nigel Dodds, to write to the Treasury and pursue the matter, which had been routinely discussed by the four Health Ministers in the Cabinet Office briefing room A (COBRA) conferences several times a week. We got the answer back in June that the Treasury was not prepared to pay.

There has been some lobbying, and I am told that the Minister of Finance and Personnel has been lobbying. It is not for me to go to the Treasury; that would be stepping on the Minister of Finance and Personnel's area of responsibility. He would be quick to complain, and rightly so. Mrs Robinson has repeated that she thinks that the Treasury is going to pay, but I wonder what sort of deal is going on that would allow the Treasury to do that. We will come to that in another place; health is too important an issue to start getting into discussions about policing and justice.

Health does not get 48% of the block grant; it gets 43% of the block grant. It comprises 47% revenue and 15% capital; our total slice is 43%. I have heard members of Mrs Robinson's party saying that we get 48% or 47% and that it is more than half of the block grant. It is not: we receive much less than half. We are talking about money, but the key issue is need. Our need for health resources in Northern Ireland runs at about 10% higher than it does in England. That has been proved — Appleby proved it. It was agreed with the joint DFP/Appleby/DHSS committee and was agreed by DFP and the Department of Health, Social Services and Public Safety.

Our social services is a subject that everyone forgets about and does not want to talk about. *[Interruption.]* Good. There is large spending on children and vulnerable adults. Our need in those areas is estimated as being around 36% higher than it is in England. That leaves us with a net figure — which, again, has been agreed on — of between 14% and 17% greater need than in England. That has been proved. Appleby said so in his report, the Department of Finance and Personnel says so, as do my Department, the chief executives of the trusts, the British Medical Association (BMA), the Royal College of Nursing, UNISON and all the other trade unions. Iris Robinson says no: who do you believe?

We have been very successful in working down our drugs budget. We pay out approximately £0·5 billion for drugs, £100 million for hospital drugs and £400 million through primary care. We have been very successful in negotiating the bill down. Andrew will talk to you about that.

Michael McBride summed up the swine flu situation. We are advised by COBRA, the Scientific Advisory Group of Experts (SAGE), the Joint Committee on Vaccination and Immunisation, the Chief Medical Officers of all four home countries and others. We take into account the experience of others, such as the World Health Organization. The response is what it is; we take that advice because that is the way to protect the population. There is a bill for the flu situation, and I negotiated, through the health budget, to write the bid for it, even though I do not bid in-year. There were two exceptions; I had flexibility over the budget for the first £20 million. I have spoken about that. Where is it? I have not seen it.

There was to be £64 million to deal with swine flu. There are three scenarios: a low-risk scenario, a middle-risk scenario and a worst-case scenario. In an attempt to get a negotiated settlement, we went for the low-risk scenario, which would cost £64 million, but I still had to pay half of that. I had to do that because, this week, for the first time, I found out what financial ground was under my feet as I looked at the contingency plans from the trusts. The trusts have had to bring through those plans so late in the year to try to balance their books, and I was not able to say, in any way, shape or form, how I could help them. I now know what financial ground is under my feet, and, as a result of last week's negotiation, I know what resources are available to me, as marginal and poor as those are. I can now address the issues around the contingency plans.

There is a pretence that the issue is all about the resource and that, if the resource were managed better, everything would be hunky-dory. Funding is increasing by 0·5% while demand is increasing by 9%. The elderly population is increasing, and the birth rate is rising. The number of admissions to A&E is increasing, and the number of day cases is increasing. There are more inpatients, outpatients, and so on. GPs and nurses undertake 200,000 consultations a week.

Our resource, taking into account pro rata need, is the least of the home countries. Another £600 million would be needed to catch up with England, which is behind Wales, which is behind Scotland. The Scottish Government decided not to take 3% efficiencies out of their health service; they reduced that to 2%. Although they are anticipating reductions through the

Treasury's initiative, which has been taken as a result of bankers destroying our financial future, the Scottish Government are increasing the health budget.

Perhaps Andrew will talk about the drugs. The Department has been penalised and criticised by Mrs Robinson in an area in which it has been successful. That is a classic example of what has happened in the past two and a half years in this Committee.

**Dr McCormick:**

A major recommendation in the Appleby report was to take further forward the work on dealing with the cost of drugs through a greater emphasis on the use of generics. The Department and the trusts carried out a major programme of work to ensure major progress on that. That is delivering significant levels of savings, and it places a strong emphasis on ensuring that the best service is provided to the patient. It has a strong quality-and-safety dimension to it. It is a major programme that is delivering significant reductions. That means that we are ensuring the best possible deal for patients in that they get the right products, and we are ensuring a good deal for the taxpayer through lower costs.

**Mrs I Robinson:**

I feel that I have to come back on the rather satirical comments that the Minister made. His corner-boy tactics do not do any good for him as a Minister.

I am delighted that the Department has managed to cut costs on drugs, and I am glad that it has a good working relationship with the pharmaceuticals industry to try to drive down the cost of drugs.

The fact that Scotland has tax-raising powers means that it is way ahead of the game in healthcare provision compared with any other part of the United Kingdom. Therefore, like is not being compared with like. I am still hopeful that the Treasury will see that the cost of the pandemic flu vaccine has caused major problems in all the regions and that, therefore, it is imperative that it coughs up moneys. The entire Committee would echo that. However, I also draw the Minister's attention to the remarks of Brian Dunn of the BMA, which were reported in today's edition of 'The Irish News', that bureaucracy and inefficiency are choking the Health Service. Perhaps the Minister should consider those comments and come back to us.

**The Minister of Health, Social Services and Public Safety:**

First, it was not Brian Dunn who said that; it was Brian Patterson. She has got the wrong Brian. Of course I have read that report. I have had discussions with Brian, and I will continue to do so. That is his opinion.

Mrs Robinson would do well to know that the Scottish Government do not use the tax-raising powers that are available to them.

**Mrs I Robinson:**

That is rubbish.

**Mrs D Kelly:**

I am sure that the Minister will support me in saying that tackling health inequalities is a priority not only in health but in education and social housing, and the SDLP's motion to protect front-line services was also about tackling health inequalities. Unfortunately, it was voted down, primarily by the two largest parties, Sinn Féin and the DUP. Consequently, I recognise the fact that you are coping with a budget that was handed to you largely by those parties.

Minister, is it not also the case that we are still dealing with the legacy of the conflict? Although people talk about underfunding over the years, much of that money was diverted to tackle the conflict and violence from which our community suffered. According to trusts' annual reports, a number of them appear to have cut social services jobs. Is that because we are no longer providing some of the services that we used to provide, such as home-help services? The delivery of some types of social services is still a postcode lottery.

Minister, we are also supposed to be talking about your priorities on the fostering strategy. Do you have a timetable in mind for its publication? In the North, far too many children and young people are in care, and we all know that outcomes for such children are poor.

I also make a special plea to the Minister to look into what is happening with the suicide prevention strategy. The Southern Trust spoke about cutting more than 20 mental-health beds. I am concerned about that, because I know that some people took their lives because proper intervention was not available to them or their families when they needed it. I understand that home-care prevention team services and acute beds for people who are at risk from taking their

own life are still not available in Belfast —

**The Chairperson:**

Is there a question coming?

**Mrs D Kelly:**

That is anecdotal evidence. However, given the present level of mental-health problems and the alcohol- and drug-abuse epidemic, I am keen to know what investment is going in to tackling those health issues.

**The Minister of Health, Social Services and Public Safety:**

I have invested in suicide prevention, and I will continue to do so. Acute mental-health beds have been used as long-stay beds, so we need to ensure that they are used for shorter stays. The average stay is 36 to 38 days, and we should be aiming for about half of that time. It has been put to me that, if people do not have a mental-health condition before spending 38 days in a mental-health ward, they are likely to feel vulnerable by the time that they come out. That is the general direction.

I am sure that you are aware that the Bluestone mental-health unit is being built in Craigavon. We are also completing two new mental-health hospitals at Forster Green in south Belfast, one for children and one for adolescents, and, given the need for a new mental-health hospital in Belfast, a proposal for one will soon go out to consultation.

As you know, mental health has been seriously under-resourced, and I have said over and over again that our resources are about 25% pro rata less than those in England, but our need is about 25% higher. Need is the key, but our having been seriously under-resourced is also an issue. During the days of direct rule, the block grant did not pay for what it needed to pay for. Provision was not made for health, so, even at 43% of the block grant, we have inherited an inadequately resourced Health Service.

We are always investing in home-help support for older people and vulnerable adults, and, nowadays, it seldom happens that home helps do not come as part of a package. I know that there are concerns, and Claire McGill mentioned differential provision in Strabane. I am always looking, and I have invested, to ensure that we have equity throughout the Province.

We have also invested in our fostering service. One of the ways in which we have done that is through paid foster carers. It is also about examining the law, and I am trying to speed up the process of adoption because it takes such a long time. If a couple go forward to adopt a baby, the child is often a toddler or older by the time that the process is finished. It is tragic that we have a situation in which there are so many obstacles before a baby or child can be adopted by a family. I am doing my utmost to try to make progress.

**Mrs D Kelly:**

Is the waiting list to have specialist assessments done by social workers and others one of the obstacles in fostering and adoption?

**The Minister of Health, Social Services and Public Safety:**

I am not clear exactly where the obstacles are in relation to a fast response, but I will write to you about that matter. It is an issue that is clearly of crucial importance. When one considers the number of referrals that are made to children's services, the number of children who are looked after, the number of children who are on the child protection register and the number of issues such as sexual violence, domestic violence, abuse, neglect, and so on, so much of that is driven — as you quite rightly said — by the misuse of alcohol.

**The Chairperson:**

Thank you, Minister. My final point goes off at a slight tangent. What does the legislative programme look like for the next few months? It was indicated that there are two or three issues in the system, and it would help the Committee to know where we stand. We know that there is forthcoming legislation for mental health, a safeguarding board and adoption.

**The Minister of Health, Social Services and Public Safety:**

I will bring forward two pieces of legislation: the adoption of children Bill and the legislation that will establish the safeguarding board for Northern Ireland. The establishment of the safeguarding board is a part of the UK-wide response to the tragedies at Soham. We also want to reinforce existing legislation. We currently have POCVA — the Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003 — and we will move into a new regime. Those pieces of legislation are about safeguarding, and they will work their way through the system.

**The Chairperson:**

Are there any timescales? We know that those three pieces of legislation will come through the system, but we have not been given any indication of dates.

**The Minister of Health, Social Services and Public Safety:**

I am being advised that I can introduce them to the Assembly in the autumn of next year. Obviously, the adoption of children Bill will have to be cleared by the Executive first. I will write to the Committee about the legislation to let you know when exactly it will come forward.

**Mrs D Kelly:**

Given that we are talking about the budget and forward programming, is the health and public safety element of the new police college still in your budget?

**The Minister of Health, Social Services and Public Safety:**

I am considering all those issues. The capital budget is under threat, as are other parts. The Fire and Rescue Service is one of the best fire services in the UK. It desires a training depot where it can light fires. It cannot do that at its current Boucher Crescent training centre. Its current base fulfils all other functions, but the Fire and Rescue Service cannot light fires there because the training centre is next door to a shopping centre.

That is why it needs to move, but the bill is around £30 million, which is a major part of the budget over the next three years, bearing in mind that we have lost about £90 million as a result of the inability to dispose of assets such as the fever hospital at Belvoir and assets in Downpatrick and Bangor. I do not know when the market will recover and allow us to dispose of those. There are a number of threats, one of which are the proposals that are currently coming through the Executive to address the made-in-Northern Ireland deficit. After that, we will have the made-in-London challenge from the London Government as they try to wrestle with the huge loans that they gave the banks.

**The Chairperson:**

Thank you, Minister. We all face very challenging times over the next few months. It would be helpful if the various reports on the CSR and deficit funding were sent to the Committee more quickly. We have been slightly hampered by the fact that we have not received the flow of information as quickly as we would have expected. We receive it eventually but not in good

time.

For example, we were told last week that the savings proposals for the Ambulance Service had been approved. The £1·5 million concerned is not a great amount of money, but we never even saw the relevant document. Can a system be set up whereby we are given adequate notice about such material, and can we see it before the BBC does? We seem to find out about many of these matters on the BBC.

**The Minister of Health, Social Services and Public Safety:**

I apologise for that. The proposals for the Ambulance Service are a contingency plan and not an efficiency plan. They were made because everyone needs to balance their books. Now that I finally know what financial ground I am standing on, I can address that. All the contingency plans will change.

**The Chairperson:**

Will we be given material before the media? It is difficult for us to respond to the media when they have seen leaked copies, and we have not seen anything.

**The Minister of Health, Social Services and Public Safety:**

No matter how one goes about it, there will always be leaks when people have discussions about this, that and the other. It is often the media who receive leaked information, but I will certainly look at how best to keep the Committee informed.

**Ms S Ramsey:**

The reason for leaks is probably that there are so many staff in the sector. Will the Minister give some background information on the Health and Social Care Board? Has it met yet?

**The Minister of Health, Social Services and Public Safety:**

The Health and Social Care Board has been in operation for a number of months. It is chaired by Dr Ian Clements, a GP, and John Compton is its chief executive. The board includes a range of representatives from across the sector. We are setting up the commissioning groups, which will be responsible for commissioning health and social care needs in each area. The board is a functional organisation, and it will determine the plan on which the trusts will deliver next year. The next step for the board will be to set up the organisations below the commissioning groups,

which concern community involvement and input.

**Ms S Ramsey:**

Brian Patterson indicated that the board has not yet met.

**The Minister of Health, Social Services and Public Safety:**

Brian Patterson — or Brian Dunn as Iris would say — has included a few inaccuracies in his article. I will point those out to Brian when I get a chance to speak to him. The Health and Social Care Board has met on a number of occasions. A few weeks ago, I met the board to express my anxiety about the Belfast proposals and to ask that they be examined.

**The Chairperson:**

The Committee will meet the board on 10 December. That will be a good chance to acquaint ourselves with the work of John Compton, Ian Clements and the other board members.

Thank you very much, Minister. Some of the officials will be staying for the next evidence session. We will take a tea break and give Dr McCormick time to collect his thoughts.