Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Acute Services Budget: Departmental Briefing

16 May 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Ms Michelle Gildernew
Mr John McCallister
Mr Kieran McCarthy
Mr Conall McDevitt

Witnesses:

Mr Paul Gibson	Department of Health, Social Services and Public Safety
Dr Andrew McCormick	Department of Health, Social Services and Public Safety
Ms Margaret Rose McNaughton	Department of Health, Social Services and Public Safety

The Chairperson: I welcome the permanent secretary, Andrew McCormick; Margaret Rose McNaughton, who is the assistant secretary in the secondary care directorate; and Paul Gibson, who is the principal of the financial planning unit. You are old hands at this, so I will hand straight over to you for the presentation, after which we will get involved in questions or comments.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): Good afternoon. Thanks for the opportunity to help you with this. I am happy to follow up on some of the points that you have just been talking about there because they are very relevant to things that we are trying to do at the moment and the difference that the Minister is seeking to make. I am glad of the opportunity. I hope that the briefing paper provided a helpful background to the topic.

The context is set by the roles that derive from the Health and Social Care (Reform) Act (Northern Ireland) 2009, which provides the framework for decision-making, planning and the delivery of services. The responsibility of the Health and Social Care Board (HSCB) to commission acute services is set in context by the 2009 Act. It seeks to secure "shift left", as we call it; a process by which the commissioning system is an end-to-end commissioning system and every part of the system has to look at the public health issues, the opportunities to promote good prevention and early intervention. All of those things are through the warp and weft of the entire system so that the commissioning of acute services is done and seen in that context. That is one reason for having local commissioning groups with that role and the Public Health Agency with its role in contributing to the commissioning plan and the requirement for that plan to be agreed by the Public Health Agency. That

is all about ensuring that we commission acute services in the context of seeking to secure change and a full public-health-led strategy.

A range of compelling factors highlight the need for reform and change in the system, as has been well articulated many times. They affect the demand and pressure on acute services, so they are highly relevant to this topic and also the wider context. They are familiar points: a growing and ageing population; increased prevalence of long-term conditions; and a tendency for there to be an increased demand and over-reliance on hospital beds. There are issues around the clinical workforce supply. Those have created some difficulties and put pressure on some aspects of service resilience. We need to be aware of that and manage that; change what we can change and work around what we cannot change. We need to focus on the obvious context, which places an obligation on all public services to deliver greater productivity and value for money. That is essential and will be clear as we go through the afternoon.

The Minister has said that, in leading change, the overriding concern is to ensure quality of care and improvement to drive up the quality of care for clients and patients to improve outcomes and to enhance the patient experience. Therefore, everything in 'Transforming Your Care' has that focus. The development of change process is about ensuring that patients and clients receive the right treatment in the right place at the right time. If things stay as they are, we will not meet the needs of the population, and things will not be sustainable. Hence, the case for change is overwhelming.

The overall aim of the proposals in the review document is to ensure that services are focused, shaped and equipped to improve quality of care, improve outcomes and deliver value for money. Therefore, there is an ongoing deliberate, intended and planned shift in care to see what can be done to reduce the extent to which care is carried out in hospitals and to increase the extent to which care is carried out in the community. However, the judgement always has to be that it is clinically the right place and the right time, with the right people and the right skills being deployed to help each individual. The case is made in the report document for more care to be provided at home or as close to home as possible and for many of the services that are currently provided in an acute or institutional setting to be provided in a community setting or in people's homes. It is about the right thing to do for individuals, and it will ensure accessibility.

The budget figures give you the current position and some information on what has happened in the recent past, but the plan, as stated in the document, will be to reduce by about 5% the budget for hospital services over a number of years, to see that deployed to increase the budget for personal and social services, family health services, primary care services and community services. Therefore, we will be looking at perhaps £21 million for personal and social services, £21 million for family health services and primary care and £41 million for community services. Those are significant increases against a significant planned and intended decrease. That is a statement of intent. Making it happen requires detailed planning so that the right things are always done at each and every stage. However, it is a very firm intention, and the implementation of the review and of the Minister's policies will take us in that direction. Therefore, the basis is there.

There is clarity of the model for delivery of integrated health and social care. We have some tremendous advantages in Northern Ireland in taking that forward, but there is an immense amount to do to make it happen and make it work properly and to ensure that we deliver good value for money in the acute sector. There are a range of interventions going on to meet increasing demand, to ensure that we live within the budgets and to look at improvements in quality and secure cost reduction.

Among those things that are being looked at and applied across the service at present are the new-to-review ratios, to ensure that there is the right balance there. We are trying to reduce the number of people who do not attend, and there have been discussions at the Public Accounts Committee (PAC) and this Committee about the issues around why people do not attend. We are seeking to reduce excess bed days; in other words not keeping people in hospital longer than they need be. We are looking at reducing average length of stay. Again, it has to be clinically appropriate, but the judgement in many cases is that what is clinically appropriate is shorter than present practice. We are seeking to reduce the number of cancelled operations and clinics; increasing the provision of day case procedures; and reducing readmission rates.

To achieve all of those requires care to be of high quality and at the right time. Many people emphasise to me all the time that it is wrong to say that quality and resources are in tension; very often, high-quality services are more economical, because they involve getting more things right first time. A lot of cost arises from poor quality. We need to recognise that and make sure that we focus on driving up quality. That will be the right thing to do.

In recent years, some progress has been made in shifting resources from acute to community-based programmes of care. That is evident from the numbers in the briefing pack. That also shows that there has been a shift from inpatient care to outpatient or day case treatment, where possible, in all these cases. So there are quite a lot of positive things to celebrate and to recognise, and quite a lot more in the way of challenges and opportunities arising from the vision and proposals in 'Transforming Your Care'.
The targets remain in the commissioning plan direction. The Minister has made it very clear that the direction is to reduce the number of those targets, to ensure that they increasingly focus on indicators of quality and outcome. Therefore, there will be fewer process-based targets and more that deal with what people want from the service. That is challenging to achieve in metrics that are usable in that context, but we are working hard to secure a better result on that. He has deliberately retained some of the obvious and mainstream targets, such as those on length of care. Although England has fewer targets than it used to, at working level there is still a big focus, for example, of 95% of patients being seen at A&E within four hours. There is still an emphasis in England and here in trying to move forward on these issues.

The Minister has emphasised the need to improve access to care in primary and community settings, as he looks to reduce avoidable attendances at emergency departments. He has also talked about ways to improve access to drugs and services that are endorsed by the National Institute for Health and Clinical Excellence (NICE). Access to radiotherapy and to medicines for MS, macular degeneration and anti-TNFs — those are things he is seeking ways to develop. He is looking for improvements in stroke and other specialist services, such as neurology, and to normalise maternity care through new ways of working — you are aware of the maternity review as well.

All of those are aspects of change. It is a complex pattern. We have to look at getting each of those detailed aspects as right as possible and ensuring that the big picture change is to shift, as much as appropriate, to the community. That remains the direction of purpose. That was my intended introduction. I am happy, either now or later, to pick up the point about the news story this morning. I can say a little about that now or wait for questions.

The Chairperson: No, say a bit about that now.

Dr McCormick: I am happy to do so. The BBC carried a story about the Southern Trust's emerging proposals in relation to community treatment and care centres. That is part of ongoing work that is entirely consistent with Transforming Your Care and with what the Minister has asked us to do in looking at infrastructure development. Clearly, an aspect of enabling the change that we have been talking about is securing good infrastructure in the primary care context. There is a range of different standards that are there at present, and a very mixed and diverse model of accommodation. Part of what it is all about is securing better integration of services between those provided by GPs, as independent contractors, and those provided by trusts and other parts of the service. Integration is a good thing. It is easy to say and more difficult to address in the complex and detailed situation that we have, but the Southern Trust and all the others have been asked to look at what they see as the priorities in relation to the provision of new buildings. In that context, the Minister wants to have a drive to secure appropriate new accommodation — where that is appropriate and needed — based on a routine assessment of priorities and needs and new opportunities to secure good integration. All of that has to be done in each local context, looking at the interests and needs of local communities. The Portadown centre is there and is working, and there has been a lot of success around that. Not all the opportunities there have been fulfilled, but there has been very significant progress. There are new buildings in Belfast and other places where there has also been significant progress. The question is where next; and the key aspect of that is by what route of procurement. That is a straightforward, orthodox, authorised piece of work. It is entirely appropriate. The trust was doing exactly the right thing in the context of examining options and priorities.

I do not think that the paper is that appropriate for wider exposure because, as you may have seen already, it is a work-in-progress document with lots of question marks and uncertainties. It is trust officers doing their job and identifying what can and should be happening and looking to draw the information together to set it in the context of the Minister's intentions. That has nothing remotely to do with acute sector reconfiguration. That aspect is being dealt with in a separate strand of work, which is the development of the population plans. Again, the Minister, John Compton, all the trusts and all the local commissioning groups have been entirely clear and open about that process. It will take its course. It will take some more weeks yet, but the intention is to have those population plans by the end of June. That will be followed by whatever appropriate processes of consultation and engagement are required before any final decisions are taken.

The acute sector reconfiguration is on a different track. There is no link or read-across from the paper that someone has shared with the BBC. On the contrary, good development in primary care will ensure that we have the right balance of services. We will achieve more of the objectives that we have been talking about, such as ensuring that there is good appropriate provision at local level. The hub and spoke model, as it is talked about, is a way of ensuring that more diagnostics can be provided in a primary and community setting as part of what can and should work, and for GPs to be linked into those processes to enable more care to be provided outside hospitals. That is good, appropriate and entirely intended.

The issue of what is sustainable and how the acute sector reconfiguration will work out is still a work in progress. There is no cause for alarm on that point at this time. The issue will be dealt with properly and all the criteria that will be used to assess the population plans focus on the long-term interests and what will actually deliver the right health and social care services for the needs of each local population. That is the intent, and that is what the Minister requires of us. I want to give considerable reassurance that those are separate issues, and that we should not put two and two together and get 65.

The Chairperson: Thank you for that and for your earlier presentation. The paper was sent to us just prior to the meeting. I have not had a chance to look at it, and I do not know whether other people have. However, it is there for people to see. One of my concerns is that a lot of this stuff comes up in the media and we are always the last to know. I appreciate that if it is a work in progress you were not expecting that to happen. If things like this do come up, we need to ensure that, as Committee members, we are alerted to the fact that there could be something there, whether it is a big issue or not.

I have a couple of points. Are you indicating that the other trusts are doing a similar exercise?

Dr McCormick: Yes. We wrote to the trusts at the start of the year. The Minister has set up a group to look at infrastructure with a focus on primary care development that involves me, John Compton and the Strategic Investment Board. Those organisations are working together to give leadership to the total system to identify opportunities and make sure that the Minister gets advice on priority-based plans that deliver the right infrastructure programme in what is a challenging context, given the major reductions in the availability of capital expenditure through the budget reductions. It makes it very challenging, and it means that they are also looking at alternative funding mechanisms through the private sector. Part of the exercise is to see whether we can get the right balance or the right mix that will work, bearing in mind, of course, that GPs are independent contractors and many of the developments that they own, rent or control are already fully in the private sector. There are some that are supported by the boards or whatever. It is a complex current model. The question is where the limited resources should be deployed across Northern Ireland, whether through the capital budget or reuse of the recurrent budget. Where is the greatest need? Where is the greatest opportunity? We need to put all that in a strategic plan. Proposals are being looked at in Lisburn and Newry to try to test a third-party development model to see whether it would deliver a good outcome. We will also see what implications that has for resourcing.

All these things need to be looked at together to secure the total objective, which is to get the services right. Buildings are totally secondary to services. It is about getting the service model right and ensuring the engagement of the provider groups in trusts and primary care to work together to provide the best service that we can make available to the public.

The Chairperson: I am glad that you were able to listen to Lesley-Ann's presentation. We are talking specifically about the acute services budget, but we will hear another presentation after this that will look at the whole commissioning plan. A lot of it is interlinked. Later in our meeting, we will look at the issue of 45,000 appointments a quarter being cancelled by the hospital because the consultant either is unavailable or has cancelled for whatever reason. That is all linked to what we are looking at.

My first question was going to be to ask where the commissioning plan is. However, it was sent to us earlier today. So members will get that as well. You probably pre-empted that question, so thanks for sending it.

Dr McCormick: It was not subtle as that. It was just that I have been slow at clearing a paper, so sorry about that.

The Chairperson: It is there, and members will have it when they come out of the meeting.

We need to look at the figures for the planned spend for 2012-13. We are six or seven weeks into this financial year where that is sitting. You talked about Compton in this presentation on acute services. I do not know whether I picked you up right, which is why I am asking you to clarify. Look at the amount of money that is spent in the acute sector versus the amount of money spent on primary care, the community sector or public health. I think that you said that you intend to reduce spending on acute services by 5%. Is that every year, and where will the money go as that goes down?

Dr McCormick: I was simply quoting what is set out as an intended direction in the 'Transforming Your Care' report. There are figures and pie charts for that towards the end of the report. That is to be achieved over the three-year period of the budget, as it stood then. I will refresh those figures. The reduction in spending on acute services is £83 million, which is about 5%. Of that, there is £21 million going into personal social services, which will increase that budget by 2%; £21 million going into family health and primary care services, which will be a 3% increase in that budget; and £41 million going into community services, which will be a 9% increase in that budget.

It is a statement of intent. I would not like to be held to those as precise budget planning figures in the sense of budgetary control. However, it is a firm intention to achieve something of that order. It will be a disappointment if we do not. However, it will require investment in change, which is why the transformation programme needs to be got under way. We need to put some up-front investment into integrated care and service change to make that happen. That is part of what is being debated in relation to the 2012-13 financial year allocations. As I say, those figures are simply lifted directly from John's report.

The Chairperson: Let me tease that out a wee bit further. In the summary of the expenditure on acute services, it is surgical, A&E and then medical. If 'Transforming Your Care' goes the way that we hope and more services are provided in the community, am I right in thinking that the money currently being spent on "medical" will no longer be spent in the acute sector? Will you define what you mean by "surgical" and "medical"?

Dr McCormick: I will let Margaret Rose take that one, but the general point of tension is that there could be a reduction in any of those areas. Some will be the ongoing care of people with long-term conditions who need to be in an acute bed when facing an acute episode or illness. The objective is to ensure the better management of those illnesses so that more care can be provided in a non-acute setting. If we prevent some of those acute episodes, that will reduce the need for surgery as well. I would not tie the change to any distinct element of that table. It is about seeking to provide aspects of support and care that allow treatment to be carried out in a more local setting and also to prevent illness as much as possible.

Perhaps colleagues will help with the definitional separation, just to be precise.

Ms Margaret Rose McNaughton (Department of Health, Social Services and Public Safety): Under heart and certain circulation problems, for example, "surgical" would be cardiac surgery and "medical" would be cardiology.

Mr Paul Gibson (Department of Health, Social Services and Public Safety): I have a list of all the specialties if that is of interest to the Committee, and I can provide that to show the split.

The Chairperson: When I read the amounts going into "surgical", "accident and emergency" and "medical", I find it confusing — perhaps that is what you wanted to achieve.

I have a question that might be more useful after your next presentation, but it is important to ask. Andrew, you talked earlier about the paper and said that much of it would be an assessment of the population plans. Where is the need for consultants if population plans are available to trusts? I have not seen the paper yet, but it indicates that consultants will be involved in planning. How can they be when you are saying that external consultants are needed to come in and give us population plans?

Dr McCormick: It is not that the consultants give us population plans; they are assisting with that work, which will be ongoing between now and the end of June. That phase of work is already contracted for with consultants. As you said, we can come to this in the later session, but the work involves many different contributors, including the board and local commissioning groups. Planning, by definition, is part of commissioning, so it is a commissioning-focused system. That is the nature of

how it works. It looks at issues such as what can and should be provided based on an assessment of the safe and sustainable services that a population will need, while focusing on the needs of each of the five population areas.

Each local commissioning group is responsible for a population area, and it has to examine what its population needs now and look ahead to make services safe and sustainable. The consultants will help with that process, and the trusts are fully involved as well. When considering the configuration of acute services, trusts are the main providers, so they must be able to assess, comment and contribute. This is a very intense and special piece of work; it is not something that we do every decade, never mind every year. We need to get it right to provide a basis for confident and appropriate public discussion and consultation. After the end of June, there will be a great deal of public process. The end of June is not the end; it is, in a way, the beginning of a process of drawing up proposals for the Minister, the Committee and the public to consider. Much of the process will, therefore, take place beyond the end of June. Putting together good plans is a very tall order. We are happy that there is a contribution from board officers; all local commissioning group members; trust staff, who are also doing their day jobs, so extensive demands have been placed on them; and additional assistance from the consultants. I am sure that John and Pamela will say more about that in practical terms in the next session.

Mr McCarthy: Thanks very much for your presentation. Andrew, you talked about the increasing demand, which we know is continual. I am concerned about mental health, mental illness and learning disability. Are there any plans to increase the spend on mental health to develop all the necessary community services and allow the full roll-out of the psychological therapies strategy?

Dr McCormick: In principle, yes. Following Bamford, the intention remains to restore what should have been the right priority. Mental health, mental illness and learning disability were neglected over many years. Since Bamford, there has been a strong commitment to address that, to provide appropriate services and to catch up with other jurisdictions where more has been provided in a community setting for many years. We have been behind in addressing mental health and learning disability. Resettlement, as an issue, remains a key target in the commissioning plan direction. There is a great deal to be done on that, and we recognise those obligations. However, increasing the proportion of the budget spent on that is much more challenging when every area is under pressure. Nevertheless, trying to do the right thing is still important.

Mr Gibson: In planning for the next three years, we have engaged with the board over the past number of months to examine what the pressures will be. Those are, for example, inflationary increases, demographic pressures and residual demand, and plans are in place to look at those areas over the next three years. There are, for example, plans to invest more in resettlement on the mental health and learning disability sides. There are demographic pressures on the acute and non-acute sides. All that should result in investment in those other programmes of care.

Mr McCarthy: That is encouraging because, as Andrew said, mental health and mental illness have always been way down the pecking order. I am glad that we now have a commitment that spend will increase.

You mentioned the importance of prevention. Is there any increase in spend on health promotion to achieve the commitment to public health initiatives as a result of the Compton review?

Mr Gibson: The target in the Programme for Government is to increase the spend on public health over the next three years. So the plan is to spend £5 million, £7·5 million and £10 million respectively over the next three years.

Mr Wells: It is strange that your announcement of a potential raft of new community care facilities caused uproar. In a normal situation, that would have been welcomed by all public representatives. However, you know the context in which the Newry situation is being considered. The problem is that, so far, remarkably little has come out about the Compton report. There has been remarkably little public concern because no names have yet been put to the facilities that are to change. I know that we are a long way off that happening. When do you think that we will know the specific reconfiguration at all levels? In Newry, people jumped the gun a bit and said that the proposal was a dreadful slight on Daisy Hill. They put two and two together and got five. When will they know for certain exactly what is happening?

Dr McCormick: The precise answer to your question is that people will not know for certain until the consultation process has been completed, which will be after the publication and consideration of the population plans. This is somewhat speculative and subject to further steps, but let me just explain, as best I can, how it might play out. At present, we are drawing up the populations plans. That work is ongoing, and those will be finalised by the end of June, which is the deadline set in John's report. The Minister wants to keep to the end of June for the publication of the population plans, at which point they will be ready for consideration. The intention is that they come to the Minister for consideration, after which there will be consultation on the plans, either singly or together. I will not commit myself to precisely how that will work out, but the intention is to consult on what emerges from that. After that, it will depend on what the proposals are, and that is when the time dimension comes in. A population plan might state that a certain service has to change in a year or three years, so there will be a timing for the further specific service reconfiguration, such as happened in the past with the consultations on Tyrone County, Mid-Ulster and Whiteabbey. Those consultations are highly specific and must rigorously address the real options in place at a very local level. That will begin when the time is right in order to provide for an orderly transition to whatever is the right emerging proposal. Absolute certainty depends on when that decision is needed and then when that consultation takes place. In some cases, it could be two years away. In other cases, it might be quite soon after the population plans are completed, because some aspects of change may require attention this year.

The fastest possible scenario — I doubt that this would apply to Newry — is the publication of a population plan; full consultation on part of the wider group of plans in the early summer; a 12-week consultation; and assessment of the reaction to consultation. At that point, well into the autumn, the Minister takes a set of decisions on the broad direction. Those decisions will provide the framework within which individual site-specific and locality-specific decisions must be taken, which will require a further 12-week consultation on the specific issues that arise.

As I said, we have two levels. First, we have overarching plans, which will not have specific details. They will not look at an individual options appraisal of something similar to what happened at Tyrone County or at any other hospital changes. That waits for another stage. I am being as open as I can and answering your question directly. It will be some time before there is certainty. The expectation is that the population plans will provide some clarity, so people will know where the issues are soon after their publication at the end of June. 'Transforming Your Care' was adamant that it could proceed only with acute services that were safe and sustainable, so the population plans will not get past first base if they propose something that will not work for the population. It would be very irresponsible of any commissioner or trust to include in a population plan something that could not deliver the care that the population needs. So the first step is to get a viable plan that will meet the needs of the population and allow the right staff with the right skills to be available and deployed at all sites. Some proposals will emerge, but nothing will be certain until the Minister has taken the final strategic decisions and the trusts have taken the final local decisions.

Mr Wells: Will there be a specific reference anywhere in the population plan to the future of an A&E department in any particular hospital?

Dr McCormick: Yes, the population plans will address that issue.

Mr Wells: So a plan will state that the implication for hospital X is an enhancement of, or reduction in, services.

Dr McCormick: The population plans will state where the service that meets the needs of the population will be located, which may involve some changes. In fact, the case for change is there, and the expectation of those who wrote the report is that there will be between five and seven major acute centres. We must be careful with the arithmetic. That counts the three Belfast sites as one. Some of the press reports referred to halving the number of acute centres, as though it were a reduction from 10 to five, but that is not the case at all. If you count the three Belfast hospitals as one hospital on three sites — the Mater, the Royal and the City — that is one of the five to seven expected in the future.

Mr Wells: Is that the first time that that has been made public?

Dr McCormick: No, that is in the report.

Mr Wells: To be honest, I read that rather differently, but thank you for your answer.

I have a more general query about the Newry situation. I liked your comment that a member of staff sought to share the document with the BBC.

Dr McCormick: I am not sure that I mentioned staff, but somebody shared it.

Mr Wells: That is another word for leak, is it not?

Dr McCormick: That is your choice of word, not mine.

Mr Wells: It was definitely a leak. Is capital funding available to provide what has been suggested? If you park the issue of its effect on acute services in Newry and Mourne, is there money in the capital budget to provide what that document envisages?

Dr McCormick: As I said, because of the shortage of capital money, we are looking at opportunities for third-party development, which would mean our using private sector money, and that would be funded from the revenue budget. That is in the draft commissioning paper that I shared with the Chair. We are talking about the possibility of finding, by one means or another, £30 million a year, which, if used to provide for revenue-funded capital investment, would allow about £300 million of capital investment. That is not unusual. As GPs are independent contractors, some of the existing developments are third party and some are provided by the private sector. The question is whether that can be expanded and whether we can find a business model that works, is viable and attractive and allows that to be tested. The proposal is to test that in the Newry and Lisburn cases, and the Minister has announced that intention. However, there are several stages of process to go through on that, and, therefore, it is a work in progress. We are working away to try to find the right answers, and the key decisions for the Minister are ahead. In some cases, those decisions will also have to go to the Department of Finance and Personnel (DFP).

Ms Gildernew: Thanks for your presentation. A table in your briefing paper refers to "earmarked funds". What does that mean? It is under the planned spend on acute services.

Mr Gibson: That category contains extra-contractual referrals, joint appointments, healthcare-acquired infection and Executive commitments. We do not have numbers against each and have still not decided exactly what those moneys will be spent on.

Ms Gildernew: The table gives planned expenditure for 2009-2010, 2010-11 and 2011-12. Presumably, the first two years have passed, so how can money be earmarked for the past?

Mr Gibson: They would not be earmarked looking back, but looking forward. Those are all planning figures and could be caught up in the actual spend against each of the other categories. They would not necessarily be identified separately.

Ms Gildernew: Is that a kind of departmental slush fund that allows you to move money about?

Mr Gibson: No, that money sits with the board.

Ms Gildernew: Andrew, you are not disappointed, are you?

It is just strange to include earmarked funds in a past tense column.

Mr Gibson: The figures were not past tense when they were created; we lifted them from the document as it was at that time.

Dr McCormick: We are trying to present a time series that gives you the planning process as it was. We can probably break at least some elements of that down into out-turn on, for example, extra-contractual referrals, which means outside the contracts with the local providers: for example, the cost of sending very expensive and highly complex cases that require referral to outside Northern Ireland, which is why they quickly add up to substantial sums. We can probably give you some more detail. I know what you are saying: earmarked is an odd term to use in that context. However, I think that we can find a way to explain the past expenditure from those amounts.

Ms Gildernew: I am not arguing with your explanation, but it would have been helpful had you included that in the paper, because we are here to scrutinise the figures. It jumped out at me that money was earmarked for two years ago.

Hospice services are only 25% funded by the Department; the remaining 75% of funding for hospice care comes from fundraising, charitable donations, and so on. Are there any plans to increase that 25%? Anyone whose loved one has been in a hospice knows the level of care and service that they provide. We certainly would not want to be without them. Many people are probably not aware that they have such a high dependency on public funds.

Ms McNaughton: You are absolutely right. Some of the work that they carry out is phenomenal. One view that emerged from a review of core funding for voluntary or charitable organisations was that the provider organisations should seek funds from the commissioners. So although the Department funded the Northern Ireland Hospice and some other charitable organisations to some extent, that money is now with the HSCB to decide, as a commissioner, what funding will go to the various organisations. Core grant funding is just managed in a different way now.

Dr McCormick: It is difficult for me to promise increases in the current financial context, but I recognise the need for palliative care. With the major sensitivities surrounding that, it is an area that commissioners need to look at in light of their responsibility for considering the totality of the population's needs. They must decide on priorities, where there should be increases and where there should be more constraint. Finding a balance between those issues is highly challenging. That is why it is right, as Margaret Rose said, that more of the funding should be commissioned on the basis of an assessment of the population's needs. It would be difficult to promise or forecast increases, but I am happy to relay your concerns to the Minister.

Ms Gildernew: Thanks, Andrew.

Mr Dunne: Thank you very much for your presentation. Earlier, the Committee discussed the variation in performance of A&E departments between trusts. I understand that 42·9% of last year's budget was spent on acute services. Do we need to spend more money on A&E to get it right?

Mr Gibson: It was 41%.

Dr McCormick: The essence of the A&E issue is that it is not just about what happens at the front door. Interventions are now being made. The Minister announced a particular drive to reduce the problems in A&E by the end of June to produce some significant change and, in particular, to remove, if at all possible, 12-hour breaches.

It is important to say that a large proportion of solutions to problems in A&E departments lie, in the first instance, within the hospital itself. Others, however, lie within community services. The reason that someone is lying on a trolley in A&E, unable to be admitted, may be that a patient who should have been discharged has not been discharged, perhaps because the package in the community is not ready. In that case, the problem for the A&E department lies not in itself, but in community services.

That is one reason why we place that as an issue for the senior management teams and boards of the organisations collectively. It has to be managed as a total system issue. That is why we hold the trusts as a whole to account. It is not right or fair to single out A&E consultants or staff, because they work incredibly hard to do the right things and to ensure that people get the treatment and care that they need. This is about total system management, which is why we need to have a drive on that. The Minister called for a major intervention. We have drawn attention, in the course of that process, to 18 key actions in relation to unscheduled care, some of which we have mentioned today. What does the evidence show makes a difference to how a trust can perform in delivering timely access to any services? There is a good evidence base, and we are in touch with colleagues in other jurisdictions and drawing on all the evidence that we can get.

My request to John Compton, as the head of the performance management organisation, is for him to satisfy me that each of the organisations is applying evidence-based good practice in a consistent and effective way. There is some very good evidence for some areas and others in which there is room for improvement. In a couple of weeks' time, I will meet John and Mary Hinds to hear their report on how that is working out. The Minister will also call for regular reports. Many things can make a difference. We know a large proportion of what those are, and the issue is mainly about applying them

consistently and ensuring good recognition. There are some inherent problems and limitations on some of the sites. They must also ensure that staff are deployed as effectively as possible.

Mr Dunne: Do you feel that you can improve performance this year —

Dr McCormick: Yes.

Mr Dunne: — within the existing budgets for acute services?

Dr McCormick: Yes. I am certain that there is considerable room for improvement in the A&E figures. As I said earlier, there are fewer national targets in England, but I spoke to a colleague working there who told me that the trust was under intense pressure from the strategic health authority to improve from the low 90s towards the 95% target on four hours. There is intense engagement, and it is challenging in that context to secure improvement because that is the right thing to do for the patient.

The Minister's focus, in the first instance, is on dealing with the significant problem of 12-hour breaches, which is the terminology that we have adopted — trolley waits was the familiar term in the past. It is important to note how the time is measured. Many years ago, a trolley wait started after the decision on whether someone should be admitted. In 2006, when we started a programme of reform of unscheduled care, we took the view that, from a patient's perspective, the clock started on arrival at hospital. Therefore, in all of our measurements, the clock starts then. The target of four hours, therefore, is from arrival to a decision to admit or discharge — in other words, for the situation to be resolved one way or the other. The target of 95% is because the clinicians advised, quite correctly, that there are quite a few cases in which it is not appropriate to try to make a decision within four hours because of a genuine clinical need to wait a little longer. Therefore, it is not inappropriate for 5% of patients to wait for longer than four hours. What is clearly wrong and not acceptable is for anyone to wait for more than 12 hours. That is where we have had a big problem, and we need to address that.

Mr Dunne: I appreciate that the implementation of the Compton report is a work in progress and that you are in the early stages. The figures that jumped out at us from our earlier presentation relate to that four-hour target: 75% in the Belfast Trust but 90% for the Southern Trust. That is a significant difference, as you recognise, and the type of issue that needs to be addressed. Much of the variation is probably down to internal processes, attitudes to work, how work is loaded and priorities.

How will health promotion fare in this year's budget? I know that the Minister is keen on health promotion and on being proactive rather than reactive.

Dr McCormick: Absolutely, and the collective intention of the Executive is extremely firm and clear in the Programme for Government targets on public health. Those include aspects of promotion and other interventions that will make a difference and secure improvement. The intention is to ensure the full and effective use of that budget so that we can be confident that the right things are being done.

Mr McCallister: I will follow on from Gordon's point. Andrew, you are confident of improvements in the A&E system, and you want to reduce the spend on acute services from 41%. However, the challenge will always be that, as you move money from the acute side into community care, you will struggle to meet those commitments and deliver improvement. Gordon highlighted the difference in performance between the Southern Trust and the Belfast Trust. It will be very challenging as you start to reduce the money going into the acute side while trying to establish alternatives.

Dr McCormick: The intention and hope is that the transfer of investment will benefit A&E performance, with better investment in community services and more efficient discharge meaning that people are not kept in hospital unnecessarily. Early intervention can prevent someone from needing to attend A&E in the first place and put some downward pressure on demand. Increasing demand is likely to remain a significant challenge, but everything that can be done to put downward pressure on demand will be done. That is part of the solution. At the other end of the sequence, we need to ensure that somebody who has been through a hospital episode gets out at the right time and is not waiting around for a prescription, or whatever.

Efficient management is central to all those matters. I remember commenting the last time that I was here that the Southern Trust has had some recognised success through lean management techniques. Most of the trusts are applying considerable effort to good management practice. It is a

management challenge to get those things right, and if they are successful, the transfer of resources will be the right thing to do. First, it will contribute to depressing demand for services. Secondly, it will facilitate improvements in community care that allow efficient discharge and, therefore, less bed blocking and better flow in the hospital, which means that A&E staff will not have to ring round to try to find a ward for patients requiring admission.

Mr McCallister: You accept that even capping demand, or slowing down the growth in demand, would almost be a success. However, you will need also to address the areas that drive the huge pressures on A&E services. It is not only about discharge; it is about access to GPs. There should be a huge public education programme on when it is appropriate to go to A&E. How do you link in the services to patients? Do you establish shared facilities across the board between full-blown A&E and a GP-led model, such as that in Downpatrick? It will be difficult to get all those in place to start to cap the demand on the A&E system or, at some point, maybe reduce it. I think that you will really struggle to do all of that while reducing the percentage investment in acute services.

Dr McCormick: I accept that it is, undoubtedly, very challenging. Therefore, we want to identify and do the right things and ensure that we have the leadership and commitment of the full teams. The process requires multidisciplinary teams to work together on the problems and apply evidence-based good practice systematically and effectively to learn from each other. Nobody has a monopoly on expertise or knowledge. People need to be receptive: they need to talk to one another and listen to what works. Small and large changes can make a substantial difference. Public understanding is vital, and that requires a confident, positive expression that these things can work. We need to ensure a positive engagement in the public domain and as much coverage as possible of that which is working. As all members will know from their contacts with the organisations, a great deal that is good is working.

Mr McCallister: Are you confident of that? The Compton report was published almost six months ago, and from the public's perspective, there does not seem —

Dr McCormick: It is understandable.

Mr McCallister: The Compton report has not been much talked about. The Committee has been involved, but from a wider Assembly perspective, not many Members have, apart from a debate soon after it was published. John talked about pathways through the healthcare system. Is good progress being made on how to identify pathways and prevent people from having to go back to their GP to be referred elsewhere, losing months in the process while still experiencing symptoms?

Dr McCormick: An immense amount of work is going on in all of those areas across the system. I appreciate that, as you said, some of it is not that noticeable at present. As you know, it is not that easy to get good news into the headlines.

The Chairperson: Thanks for your presentation and your answers to some of the questions asked and points raised. You are staying with us, Andrew.