Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Workforce Planning in the Context of Transforming Your Care: ICTU, NIPSA and UNISON

29 April 2015

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 Maeve McLaughlin (Chairperson)
Ms Paula Bradley (Deputy Chairperson)
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Paul Givan
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Michael McGimpsey
Mr Fearghal McKinney
Mr George Robinson

Witnesses:

Ms Claire Ronald	Irish Congress of Trade Unions
Ms Anne Speed	Irish Congress of Trade Unions
Mr Kevin McCabe	Northern Ireland Public Service Alliance
Mr Jonathan Swallow	UNISON

The Chairperson (Ms Maeve McLaughlin): I welcome Anne Speed, the chair of the Irish Congress of Trade Unions (ICTU) health committee; Claire Ronald, the vice chair of the ICTU health committee, Jonathan Swallow, a UNISON consultant; and Kevin McCabe, the assistant secretary of the Northern Ireland Public Service Alliance (NIPSA). Kevin McAdam could not attend today. We invite you to make your opening statement, after which we will open up to members' questions and comments.

Ms Anne Speed (Irish Congress of Trade Unions): I am Anne Speed from UNISON, but I represent all the affiliates to the Irish Congress of Trade Unions. Good afternoon, everybody, and thank you for the opportunity to give this presentation. First, I will make an opening comment, which is meant with respect to the Committee. We represent between 225,000 and 250,000 people. We are very pleased to be here. We note that the sequence of invitations always seems to start with the medical profession and those who might consider themselves to be the elite. I would like to remind the Committee that, in our own ranks, we have professional and nursing staff, because I notice that the royal colleges, as they are called, were invited separately. We have thousands of members across our organisations in the nursing profession. In the future, perhaps we might be the first in the door, as we represent not only those who work in the service but the users of the service, and our membership and their families have a huge interest in what is happening to the health service.

Secondly, the Irish Congress of Trade Unions has trade unions affiliated to it. Today, I will make observations from a broad strategic or policy approach, but we would like to remind you that, when

UNISON, Unite, NIPSA or the Chartered Society of Physiotherapy (CSP) are mentioned, we have our membership in our affiliates inside the bargaining structures. My colleague Claire represents all the allied health professionals (AHP) in the bargaining body. I represent UNISON in the bargaining body. I remind you of that, because I think that people sometimes get confused and look at NIC-ICTU as being equivalent to UNISON. It is not; it houses all the unions, and we are all part of the general trade union movement.

We have serious concerns about the process for the workforce planning developments to date. Some two years ago, we raised the issue of workforce planning and were advised by the Department of Health, Social Services and Public Safety (DHSSPS) that the only workforce planning taking place was as part of Transforming Your Care (TYC). We were then informed a little later that there was an initiative at departmental level to do with workforce planning structure that would address the tools required for workforce planning and that there was no space or opportunity for us to be involved. We were advised that it was not relevant to us. We have arrived at a point at which a workforce planning structure has been established: the regional workforce planning group (RWPG). We have not been invited. We have had sight of some paperwork. There was a consultation document in September, and we had sight of the evidence presented to you in March this year, but we have not been invited in.

What concerns us in the documentation is that the Department seems to have adopted the conclusion, or certainly a perspective, that we should engage at stakeholder level. We believe that workforce planning requires more engagement than that: we need to be involved as partners. Regrettably, we are dealing with the reality that the Minister — we believe on advice from the Department — closed down the partnership forum. We were not consulted; we were simply told that it was not happening and that anything we had to say could be said in public consultations and in the bargaining forum. The bargaining forum deals with agreements to be made, implemented and overseen. The strategic partnership forum is about vision and planning the future. It is a commitment to that, and we expect to be in there as equal partners. We have not been.

In the Department's evidence to the Committee in March, it said that it is responsible for setting the strategic vision — I refer directly to the report — and that, as far as it is concerned, we have no role in the collapsed partnership. The commissioning body and the Public Health Agency (PHA) say that their role is to agree the models of service delivery. We are now faced with review upon review upon review in which we have not been involved as equal partners, although we may have been invited to engage in conversations. In domiciliary care, I think that there are at least four reviews. The trusts are responsible for ensuring that they have an appropriate and skilled workforce to deliver workforce planning. We have had some involvement across the trusts — it would be wrong to deny that — but it has been slow off the mark, is still in the early stages in some of the trusts, the local involvement at this stage leaves a lot to be desired, and it seems to be entirely connected to the TYC strategy, which is a narrower framework than we think possible or necessary.

As far as we are concerned, workforce planning should start from the needs of the service as a whole, the delivery to patients and the journey that they take rather than amount simply to a strategic approach, for example, to shift left, moving from acute delivery to community delivery, with all that that involves. TYC itself has come under serious review and, certainly for us — maybe even for you — has lost a lot of credibility. I hand over now to my colleague Claire Ronald, who is vice chair of the committee.

Ms Claire Ronald (Irish Congress of Trade Unions): I represent some of the smaller professions in the bargaining forum. One of the problems that we have with workforce planning and with not being involved at the earliest stages is that it is done in silos. Instead of thinking of the patient pathway or journey, we look at workforce planning for GPs, medics and nurses. You took evidence from the British Medical Association (BMA) and the Royal College of General Practitioners, and they were obviously picking up on the crisis in GPs, yet one of the solutions to that crisis is to look outside of GPs. At the moment, about 20% of GP referrals and workload are musculoskeletal conditions, yet the pilot for self-referral for physiotherapy was postponed under TYC and is starting only now, and it is starting as a pilot to evaluate it, when we know that it delivers. We know that it delivers cost savings; we have evidence from Scotland and from the areas in England that have made the change that show that it delivers, but we do not have that joined-up workforce planning. We are planning in silos, and, when you plan in silos, the answer is always going to be that you need more of that profession and are not going to think outside the box. If you truly want to transform delivery, you need to look slightly differently at how you plan your workforce. If, as trade unions and professional bodies, we are not in at the highest level, we cannot influence the decisions that are made.

Ms Speed: I call on Jonathan Swallow from UNISON to present.

Mr Jonathan Swallow (UNISON): I will simply highlight some key elements of the evidence that UNISON has submitted that are relevant to your inquiry. We have pointed to the interesting current context, whereby reshuffles in the Health and Social Care Board (HSCB) seem to slow down the delivery of TYC fundamentally. We have also highlighted the latest figures that show that the shift left in the trusts appears to be blocked. Moreover, new investment of £9 million will hardly buy very much innovation or change. Going back to your discussion on GP numbers, we were amazed to discover that HSCB records do not show the number of GPs and related staff per practice funded. That was admitted by officers at the board. Clearly, planning is difficult in that environment. As indicated, we have highlighted the different reviews of domiciliary care. UNISON is involved in the HSCB review, but we have no involvement in the current workforce planning initiatives and nor do any of the unions.

In answer to the questions you put to us in your invitation, we were particularly disturbed to see that the target in last year's ministerial direction for district and community nursing normative staffing no longer exists in the latest direction. It is also very concerning that a number of targets have now been slackened off, making any performance comparison between this year and last year fundamentally misleading, given that, in just one example, 80% of people and now 65% have to wait 15 to 18 weeks.

I move now to confidence in workforce planning. We remain very disturbed by the statement in the original proposal for integrated care partnerships (ICPs) that there be an evaluation, including conversion of the entire pathway to a social enterprise. That does not create an environment of confidence. Members have asked us whether they are at risk by participating in such a process. That question should not have to be asked.

You quoted the −3% staffing figure. We support the PHA view that the growth in demand is exponential and that, therefore, that figure cannot be credible. In particular, I highlight mental health and the King's Fund analysis that shows 50% underfunding. The latest figures that we have seen show a 25% higher presentation rate than in England. With figures like that, the original quoted cost of −3% in staffing numbers cannot be achieved. The best you can do is to try to contain growth.

As far as your specific question on learning disabilities is concerned, UNISON is actively engaged in a complex, tough workforce planning exercise at facilities such as Muckamore, and we continue to support unconditionally the principle of resettlement. We have absolute unconditional support for that correct concept. We have to deal at workforce level with the consequences.

I move now to day centres. We are looking to take the language of TYC and reinstate the real meaning of "hub" and "spoke" in which the day centre becomes the leading light — the leading source — of care in an area rather than being marginalised and downgraded. That also has major workforce planning issues. Thank you, Chair.

Ms Speed: Finally, Kevin McCabe from NIPSA will address what is happening with social workers and administrative workers, in particular, in the system.

Mr Kevin McCabe (Northern Ireland Public Service Alliance): NIPSA represents various grades and disciplines. I will start with social workers. We want to ensure that there are sufficient numbers of social workers to meet the requirements set out in the 10-year social work strategy, which was launched by Minister Poots. There has been evidence of improved work processes, multidisciplinary working and integrated working across the service, but we think that it is important that proper analysis is carried out on the strategy, which deals with flexible working and 24/7 working. The number of student placements and demand and supply need to be analysed to match the needs of the workforce with the aspirations in the strategy.

The second area relates to admin and clerical staff. They number 3,500 in the Belfast Health and Social Care Trust alone, but it has always been our view that such staff should be considered front-line staff, because we are very clear that, in their absence, clinics would not operate, consultants would not be able to carry out their duties, and, if not properly resourced, there would be a systemic failure in a range of services. There is evidence that shows that they have been crippled by vacancy controls. We ask the Committee to give consideration to my comments that they are the unsung heroes in many ways because of the support that they provide to clinicians and to keeping the service afloat.

Finally, I turn to the social care workforce, from which NIPSA and sister unions have members. We believe that they are being targeted by privatisation and value-for-money audits, which are the twin themes of procurement and privatisation in the 'Vision to Action' TYC consultation document. We have seen reports from the Regulation and Quality Improvement Authority (RQIA) and others, and it is

our view that, where work is being outsourced, it has led to a decline in standards. In some areas, we have seen award-winning, quality-assured professionals replaced by less skilled, less qualified or less experienced staff. That needs to be given due consideration.

The Chairperson (Ms Maeve McLaughlin): Thank you all. There is an increasing sense that TYC is being questioned as a viable strategy. It is called a "vision without action". I certainly have my own views that it was the right policy direction but that it was not validated by any strategic evaluation of investment or an outcome framework for health inequalities. Is it dead or, if it is dying, can it be resuscitated?

Ms Speed: Jonathan, would you like to answer that?

Mr Swallow: I think that it will go through a three- to six-month hiatus, with an internal restructuring of roles in the HSCB. A better look is needed at what the funding has achieved. In particular, I highlight my note on the proposal to produce an update on the original 99 proposals, which could be of great interest to the Committee. I think that the funding environment is now at the cusp of risk to patient safety. The Committee may wish to know that, of the £90 million in cuts that the HSCB demanded of trusts, only £60 million has been taken forward because the remaining £30 million was ruled out by the Public Health Agency as compromising and risking patient safety. We currently have savings plans that rely on the falling price of fuel and the misuse of vacancy control as a low-hanging-fruit saving that compromises performance targets. In that environment, we see the future for the current TYC process as very challenging.

The Chairperson (Ms Maeve McLaughlin): Did you just say that £30 million of those proposed cuts were a risk to patient safety?

Mr Swallow: They were judged by the PHA to compromise or create risk and were, therefore, taken out of the trusts' savings plans. Trusts have put forward £60 million of savings when they were originally asked for £90 million. We found the process very concerning, whereby the situation was so desperate that such proposals had to be brought forward and that the PHA had to say that the trusts should not do it.

The Chairperson (Ms Maeve McLaughlin): That should be of concern to us all when you get an analysis of potential risk.

Mr Swallow: We are seeking the detail of the £30 million that was not taken forward. That has not yet been made available.

Ms Speed: We are seeking the trusts' delivery plans as distinct from their savings plans, post the publication of the commissioning plan by the board. We will have a closer look to see what the practical, on-the-ground implications will be. I think that close scrutiny of those delivery plans should also be the business of the Committee.

The Chairperson (Ms Maeve McLaughlin): We can and should influence that. I am staying with the overall context, because I think that this is the critical part, not only with workforce planning but with Transforming Your Care generally. There seems to be a growing consensus that, at the heart of the problem, the system is flawed in the way that it is currently configured. We see a system that has a lack of clear roles and is overly bureaucratic. There is a lack of transparency. Decisions go in and out through a system, and there does not seem to be a lot of accountability. There is an increasing sense about decision-making processes and good use of public money. As a union representing huge sections of society, is your sense that the system itself, as it is configured, is flawed? If so, what needs to alter to ensure that things like workforce planning can be responded to in terms of need?

Ms Speed: I will ask my colleague Claire to respond to that.

Ms Ronald: I agree with you that, on the ground, we see a flawed system. People do not know how to get into the system. The feeling for us, as trade unions, is that we are being actively excluded from the system, even the regional workforce planning group, despite asking at the earliest opportunity if we could be at the table and involved in those decisions. Suddenly, we are down at stakeholder level and not able to influence to the same extent. When you speak to staff on the ground, many of whom have good ideas, their answer is that they do not know where to take it. Who is accountable? Who do you go to? Is it integrated care partnerships? Is it commissioning groups? As a physio, are you going

through an AHP group? You have so many levels to go through that can reject what you are suggesting. As I said, the self-referral pilot in physio is a classic example. It has been demonstrated that it releases savings elsewhere, but we had to jump through hoops, and it was suddenly withdrawn. The South Eastern Health and Social Care Trust was in the preparation stages and ready to roll it out, and it was suddenly withdrawn. It is no longer in the plan, despite being in the commissioning plan and the DUP manifesto. You feel as though you are running on a treadmill and constantly coming back to the same problems. Things that we highlighted two years ago are now happening. We are back asking about the same things and running on the same treadmill.

The Chairperson (Ms Maeve McLaughlin): In your view, how does commissioning change?

Mr Swallow: Last week, UNISON spoke briefly at the Northern Ireland Confederation for Health and Social Care (NICON) conference. We set out three principles for radical reform: bringing the system back to financial sustainability; ending health inequalities; and raising general performance. We have key principles underlying that, including the end of the commissioning/provider split, which is the legacy of direct rule; single-point leadership and accountability so that somebody has to be responsible; the end of all outsourcing and privatisation; and to go back to previous performance targets, not those sanitised in the latest ministerial direction. I will be happy to arrange for that press release to be circulated to all Committee members.

The Chairperson (Ms Maeve McLaughlin): That would be useful.

Finally, Jonathan, you referred to the 3% reduction in staff that was a component of TYC. It has now been discovered that that was a working assumption. You indicated that you actually need an increase in staffing and the workforce to deliver TYC. Do you have a figure or an estimate for that?

Mr Swallow: Not at this stage. I think that we know that, in every aspect of the service, demand is increasing, so we need to model that increase in demand. I cited the increase in mental health. We have seen the desperate state of statistics for A&E units. We need to move away from the current approach of the Department, which is to state in the commissioning plan that this is what it is doing with the current budget and to go back to the correct approach, which is to model increasing demand and unmet need and then state the answer. We are very concerned about the culture in the Department of simply cutting the coat to fit the cloth rather than looking at unmet need.

Ms Speed: I would like to add two sentences. First, when TYC was first published, we said that the 3% was financial, was not based on an estimate of how the service would change and that there was nothing behind it. We have been proved right. Secondly, in the bargaining structures in which our affiliates are involved, at the last meeting of the regional bargaining body, a proposition for voluntary exit was put on the table. We asked where the analysis was. How does this fit with workforce planning? Where do you think the voluntary exits are going to occur? Until such time as we get proper and coherent analysis of where the service might do without staff — we believe that the service is crying out for staff — we will not entertain that. We insisted that the voluntary exit scheme came off the table. That is the kind of haphazard approach at departmental level, which is filtering right down through the structures. We have a perception of committees and bodies bumping into each other and cross-referencing, with a whole load of people doing the same thing and a whole load of money being spent on it. That is our sense of it.

The Chairperson (Ms Maeve McLaughlin): Finally — I said "finally" the last time; I am going to use my position as Chair — is Scotland moving in the right direction?

Ms Speed: I will ask my colleague. She has a co-location responsibility, so she has experience in the Scottish health service.

Ms Ronald: It is difficult. I have worked as a physio in Scotland, so that is what I knew. In this role, I cover part of Scotland and Northern Ireland. When I first came to Northern Ireland, I assumed that it would be a very similar situation, but I have to say that, four years into the post, I still do not understand clearly where decisions are made. It is constantly changing. One thing that I will say is good in Scotland is the fact that partnership is embedded at the very heart. That can be seen in the number of meetings that we have and the ability to get into the Department and chat to the Department. As soon as groups are set up, the first thing that they do is to write to the staff side and ask who the appropriate person would be to sit on a group from the staff side.

Wales is slightly different from Scotland, but it is interesting that both took a stand against privatisation. A firm stance not to outsource the NHS is still not embedded here. That is the other fear with TYC.

Committee structures and funding in Scotland seem slightly easier to follow. The Minister gives money to the health boards to make appropriate decisions at that level, which are tied into the targets that are being set. It is also about following the money, who decides who gets the money and where the money goes. There seems to be so much short-term funding here. I think that you could learn from Scotland, but you have to be aware that it is a very different structure.

The Chairperson (Ms Maeve McLaughlin): Has Scotland moved back to the traditional NHS cooperative?

Ms Ronald: Yes. It has no purchaser/provider split, and a lot of private care is coming back into the NHS, which is the big move. The Golden Jubilee National Hospital is a prime example. It was a private hospital that was bought back by the NHS. The new South Glasgow University Hospital has just opened. People are nicknaming it the "death star" and all sorts of horrible things, but it is a state-of-the-art hospital that was not funded through a PFI. There are no loans to be paid on it; it is a government-funded building, so there is no outstanding loan to drag us further into debt.

Ms Speed: I think that I am right in saying that the Assembly passed a motion — I think that it was tabled by Conall McDevitt — on privatisation. It stated that, if further strategic decisions were to be made about any of the public sector, there would be a review by the Assembly or the appropriate Committee. I think that it was something like that. I wonder whether that Assembly decision has disappeared, because it should be the mechanism by which you do your business.

Mr McCarthy: Thank you very much for your presentation. I start by acknowledging your comments, Anne. Let me say loud and clear that I have 100% faith in you and your colleagues. You should be at the front in any negotiations to make sure that the people whom you represent get nothing but the best.

I have a number of questions. You mentioned self-referral. My understanding is that it was to have been implemented. We were all excited about it, but, for some reason, it has not been implemented. As far as I know, Chair, we were informed that it was coming back somewhere.

Ms Ronald: A pilot is starting in the South Eastern Trust.

Mr McCarthy: We were as disappointed as you that that has been knocked back for some time.

One of the terms of reference for the Committee's review is to examine the Department's approach to involving staff and staff-side organisations in the workforce planning required to implement Transforming Your Care. I know the answer to this, but I will ask you anyway: how do you assess the Department's approach to date?

Ms Speed: Abysmal. It is completely unengaged with the majority of its workforce, and it is without any clear indicator of what exactly the next steps will be. We note that there is some engagement at trust level, but, because we have not been engaged at the centre, we do not know the framework in which the trusts are approaching the question. I think that, in reality, it is very much focused on the immediate needs of the trusts and maybe dealing with issues like vacancy control rather than strategic overview planning for the medium to long term. Engagement or involvement with us has been non-existent, and we are very critical of that. I repeat this point: why would you close down a partnership forum when such a significant dialogue is starting on workforce planning? It makes absolutely no sense. In our opinion — I will choose my words very carefully because I do not wish to be disrespectful to the Department or its officials — it shows a complete lack of understanding of the distinction between strategic and policy engagement, and actual negotiation and bargaining. That is at best; at worst, it indicates a prejudice that there is no place for us. We are not sure which of those two opinions really holds sway.

Mr McCarthy: Following on from that, last week we had representatives from the nursing people in, and we had the midwives. I —

Ms Speed: Representatives of some of the nursing profession, if I may —

Mr McCarthy: OK. I asked those individuals whether they had any faith in the people who are running the Department. I think that is the question I asked: whether those who are running the Department know what they are doing. Can I presume from your answers so far that you think that they probably do not know what they are doing?

Ms Speed: Well, I would not have a lot of confidence. Individually, the people who work in the Department are probably decent people. They need their employment like everybody else. However, as a coherent arm of the Executive, and for delivery of service, I do not think that it is acting in a coherent manner whatsoever. Then, of course — we do not want to gild the lily — it has had two Ministers leading it, and there is a job of work to be done to ensure that the next Minister who steps forward is there for the long term and gives good guidance to the Department.

Ms Ronald: I just want to come in briefly on the question of whether the people in the Department know what they are doing. Even in their own evidence, they highlighted that they had to have Skills for Health coming over to do training for them on workforce planning. That shows quite a big gap in the Department, if they did not have that skill set and had to build it up. We are now how many years into TYC? They are only now looking at the skills for workforce planning. That is quite frightening.

Ms Speed: I suppose a crude way of saying it is that they are all over the shop.

Mr McCarthy: In a similar vein, is it clear to you who is in charge of workforce planning? Is it the Department? Is it the board? Is it the trusts? Or are they all over the place?

Ms Speed: They all say they are in charge, according to their evidence. Kevin, would you like to answer that?

Mr McCarthy: And could you comment on your confidence in them delivering?

Mr McCabe: We all know that they have discrete functions, but I want to tie my points to the Chair's original proposition. In leadership and outcome, you need to know where the strategic direction is going. Just last week, you were getting mixed messages, which leads to confusion about where we are going and the strategic direction. You have the Health and Social Care Board chief executive saying that it is still the only strategic direction for the Department, but it needs rebranding. We have politicians calling for the scrapping of TYC, and we have heard other politicians calling for a review of TYC. It is a vision and a plan drawn up by people, but it is clear that it was never underpinned by legislation or by any strategic analysis and agreement that that is the way forward. Fundamentally, in all the submissions that were made, no one disagreed that a shift from acute care to community is necessarily a bad a thing, but it needs to be properly resourced. The shambolic outworking of TYC meant that transitional funding had not even been met, let alone the £83 million. You have to join the dots together. If the funding is there and you can move and see the strategic direction, you can then start to look at workforce planning and numbers.

To answer Mr McCarthy's question, at the moment the Department functions separately from the board; it functions separately from the Public Health Agency. Of course there has to be some coordination and working together, but the big hole is the general direction of health care and the question of what is the right model. Scotland is one to look to, but it requires all the stakeholders to come together to reassess or review where we are going because, if the funding is not there, how do we plot the way forward?

Mr McKinney: Can I jump in there, Kieran?

The Chairperson (Ms Maeve McLaughlin): Kieran, is it OK if Fearghal comes in on that?

Mr McCarthy: Yes.

Mr McKinney: Maybe this question is a bit leading. I think that you are right that there are different approaches to the TYC concept. However, TYC was at least on paper; it had been consulted on; it had 99 targets. If it has now morphed into some vague conversation about transformation, is there a danger that we will not have anything to pin the measurements, finance and strategic direction to? Do you, therefore, share the concern that TYC may disappear, perhaps because, as Valerie Watts said last week, it was published in the context of 2011 and things have now changed? I am really asking

whether there is a danger that the construct of TYC, as it was originally, will disappear, and, with it, the strategic direction.

Ms Speed: They tell us that it is mainstreamed and measured. Jonathan, would you like to come in?

Mr Swallow: I would like to see the detail of the statement mainstreamed into general commissioning. That has just been a statement in the last few weeks; there is no detail to unpick from it. I would like to see an end to the Department's sanitisation strategy, including the concealing of performance information and changing of targets. That general approach totally weakens the process. We have to look at how many people are needed to do the work; that is the essence of workforce planning. We now have a statement that normative nurse staffing, including the critical issue of district and community nurses, is now not to be achieved until March 2016. The HSCB report said that we have no investment. Without those issues being resolved, TYC becomes a series of low-funded projects that do not make a visible difference to the critical issues facing health.

Mr McCarthy: I am sure you will agree that the loss of another Health Minister will not help any of us in this cause and the direction that we are travelling in. You mentioned that you were not represented on the regional workforce planning group. Do you believe that will hinder communications between you and the Department and, indeed, the workforce?

Ms Speed: Absolutely. There is a body of people with authority and power in the health service influencing budgets. They are planning the future, and we are not there. Taking into account all the organisations, including the medical people, our own membership — there are 60,000 employed — and all the professional and trade union bodies, we must represent more than 50,000 people. Of that, the affiliates of the congress are the largest block, together with the RCN and RCM. No one is having a conversation with us.

Mr McCarthy: That brings me back to the question of whether those at the top know what they are doing. Surely you should be among the first people to talk to. Last week, the representatives told us that they were not on that group either.

Ms Speed: The RCM and the RCN, yes.

Mr McCarthy: Surely you should be the first people to be brought in, with your hands-on experience of what is going on.

Ms Speed: When you have bureaucratic layers upon layers, there are people employed in those structures who believe that they do know, and they take it upon themselves to make the decisions. There is a load of people who think that they know best, and that is what happens when you have a bureaucracy that is out of control. They believe that they know best, and that is the difficulty. Unless you take the evidence and experience of the people who are actually delivering the service on the ground, how can you evaluate and come up with plans for the future?

Mr McCarthy: Finally, Chair, I have a question for Jonathan. You mentioned Muckamore Abbey, and I have a particular interest in how Muckamore Abbey finishes, as it were. Are you satisfied with how that is going? Obviously, there are still patients or clients in Muckamore. Are they being looked after in the way that they were supposed to be?

Mr Swallow: As far as we can tell, the clinical standards remain good. As I indicated, the principle of resettlement is unconditionally backed by UNISON. Our members are going through quite fundamental change processes because people will not be there. It needs to happen and, as a union, we fully endorse the process. We have seen no issues and had no reports of any failure of clinical standards or care.

Mr McCarthy: I am glad to hear that. I presume that the deadline has gone, because there was a deadline to have that completed. It has not been done. Are you still happy that there is no push to get people out into places where they ought not to be? That is my concern.

Ms Speed: We are keeping a close eye on that.

Mr Swallow: It is proper and professional, but we follow the pace of it because of the workforce planning issues.

Mrs Cameron: Thank you for your presentations. Following on from Kieran's last point, as part of the shift left under TYC, the Department has told us that around £25 million has already been shifted from hospital services to community primary services, specifically in the area of disability and mental health resettlement. We have heard about the patient side of things, but do you have information on what the impact has been on staff?

Ms Speed: I do not have in-depth knowledge to share with you today, but we did get a presentation. We have a structure called the TYC engagement forum, and the directors from the board come and give us a presentation on what is happening. The mental health area is probably the better of all that has happened across the service in attention to dealing with the deficits or change. It is probably one of the better areas but, as we outlined in our presentation, there are still difficulties.

Even though we have asked for it three times, we have not yet seen a breakdown of where the £25 million was spent, how it was spent and where it was applied. When we go into rooms and hear fine presentations delivered by very pleasant people, we look for the detail, because that is what matters. There is no breakdown yet on what has been spent to date. Equally, to slide in another issue, we also asked for a breakdown of the savings that were to be accrued under shared services and the continuing debacle with the payroll issue. That is for another day. We do not have that information either.

There appears to be a lowering of the importance of engagement with the representative bodies, which seems to be percolating through the structures and across all the bureaucratic layers. Everybody is under pressure because of budget deficits. The directive to balance the books went out and everybody is scurrying around doing that, but, in the middle of all of that, we are undertaking important work and consider ourselves to be the guardians of not only our members' interests but the service that our membership — 250,000 of them — receives. It is just not happening. We are not getting that information. I will happily seek further information and send it to you because that is an important figure that we need to deconstruct.

Mr McCabe: To complement what my colleague said, I do not think that there is an issue with mental health because, by and large, the Bamford review was endorsed, but, unfortunately, only some of those recommendations are in TYC. Bamford was universally felt to be the right way forward. Going back to the point that Jonathan made, even within those 99 recommendations under TYC, a lot of the programmes of care were already being implemented. Part of that was already in place in programmes of care and the direction that they believed they had to travel, subject to funding. Again, I note that quite a number of organisations said that Bamford was the way forward. However, it is costly, and you are seeing partial implementation of that.

Mr Swallow: I would like to add, Chair, that the crucial figures will be in the 2015 commissioning plan, which is currently being exchanged in draft between the HSCB and the Department. Its final approval by the HSCB is on 14 May. We will be seeking to make comments during that meeting as to whether it addresses the issues raised by members here about mental health funding, for example. The last three plans have done nothing to address the 50% underfunding and the 25% higher presentation rate. That will be a key element of our scrutiny of that plan.

Mrs Cameron: Would it be wrong to presume that there has not been a big impact on the staff in that area?

Ms Speed: I cannot give you hard evidence today about the impact on staff, because we are trying to gather it. Jonathan made the point about there being underfunding in the first place anyway. I think that there have been some shifts and changes, and some of them have been positive rather than negative. We will get the statistics on the impact on staff for you, but we are still trying to find that out ourselves. Since we are not at the table on workforce planning, we cannot see closely where the detail is, but we will get that for you.

Mrs Cameron: Thank you.

The Chairperson (Ms Maeve McLaughlin): On the impact, if there is a shift from hospital to community care, what does that mean for staff? What does it mean for staff who are not now working

in a hospital setting but in the community? Those issues need to be looked at. It would be useful if you could pick up on that information.

Ms P Bradley: I declare an interest as a member of a union. Thankfully, I am still a member of a union, because in 13 months I may require that union if I am not re-elected and need to have a journey back into the Northern Trust.

Ms Speed: We are delighted to have you with us.

Ms P Bradley: I will stay with it in the meantime; my career break will be over by then.

I want to pick up on a point that Kieran made about unions being present and being part of the discussions. I wholeheartedly agree. When I was elected in 2011, I had just left an acute hospital setting and had become a member of this Committee. I heard briefings from the Department, the heads of trusts and the board, and I remember sitting here many times thinking, "I do not recognise that". I knew that what we were being told did not happen when I worked in Antrim Area Hospital. I was thinking, "That's not right. Where are they getting their information from? How is that information being fed upwards?". Without the likes of you people, who are feeding the information from the ground up —

Ms Speed: You are getting the glossy version.

Ms P Bradley: I am at a loss as to where they got some of the information from, because some of it was totally and completely off the wall. So, yes, I believe that there are many instances — I am not saying all instances — where the unions are most definitely required. I also thank the two members at either end for bringing up social work. When we talk about allied health professionals and other parts of the service, we often forget about social work. I know how much pressure that service was under, even going back to 2011. The Chair brought up the 3% reduction in the workforce: I remember thinking, "How on earth could we have sustained a 3% reduction in that workforce to meet the needs in the community?". It just would not have been able to happen.

I want to go back to what we heard last week from the Royal College of Nursing about the last four years, the reduction in our district and community nursing and how that is absolutely not in line with TYC. We also heard from the BMA, and we heard about the wonderful initiatives that we now have for treating people in their home and providing acute care at home. All those things are fantastic and in line with the TYC. However, Jonathan, you said in your briefing how concerning the reduction in our district and community nursing was. You also mentioned other disciplines in our health service. Have we any evidence to back up the claim that there has been a decline in numbers in the disciplines that we need in our communities to bring Transforming Your Care forward?

Ms Speed: It takes a little bit of time to decipher the published workforce statistics, because the headcount hides the fact that there are bank and agency staff, and there is definitely a decline in the number of permanent employees. There is an increase in people carrying more than one contract. You have heard evidence about the cost of agency working, which is itself a burden. Our experience is that, in every workplace, there will be somebody missing, and those hours will be covered by either bank or agency staff. We do not use overtime except, I think, in the Ambulance Service. Then there is the problem of health workers having to extend their shifts and cover shifts that they should not be covering. There are a lot of practices that, if you took a microscope to, you would say, "Uh-oh, there is a risk factor there."

You probably know that a number of organisations are engaged in industrial action or action short of strike. One action is trying to illustrate where the actual staff shortages are. We have started logging in the extra time that nurses, support workers, catering staff, porters etc are all doing over and above their shifts. We will compile that evidence and bring it before the Committee. It was previously notified in the survey in 2012. I think that 49% of staff work over their time.

Ms P Bradley: I can assure you that, when I worked in Antrim Area Hospital in the social work team, none of us left at five in the evening; that just did not happen. That was when you did your write-ups. I know that. I know the number of hours I worked that I was not paid for and that are done in so many disciplines across the board.

Ms Speed: We are trying to look at the latest figures and deconstruct them. The other thing that we have noticed is that, when we apply for representatives to be released for training — very necessary training to do with health and safety, for example, which the employer is legally obliged to release people for — they cannot be released because of a shortage in a particular ward or workplace. There is a lot of empirical evidence and hard stats. That is the job of work we are undertaking at the moment.

Ms P Bradley: It is important to get those figures across the disciplines, because all of them play such an important part in the complete multidisciplinary way of working.

Ms Speed: Claire wants to add something on AHPs.

Ms Ronald: It is difficult in my profession of physiotherapy to measure and get a handle on the number of posts that are on non-recurring funding, and have been for two or three years. These are services that trusts rely on, such as physiotherapy in A&E, which provides a benefit, but the physios are all on non-recurring funding. Staff are seconded from other posts, which means that we do not know the figures. When it comes to measuring staff, you do not know how many are substantive and how many should be funded. That is a fundamental part of workforce planning. We do not even do workforce counting properly.

Another thing that we are very poor at measuring is unmet need. We have physios working to prioritisations that were drawn up for a flu pandemic. That is what they are working at from Monday to Friday, and now they are asked to look at seven-day services. You cannot take a service that is not functioning over five days, or is functioning at crisis levels, and expect it to do seven. We know that there is a need, but we are not having that strategy discussion about what we stop doing, what we do more of, where we put our limited, finite resources and when non-recurring posts have to become recurring and part of the establishment.

Ms P Bradley: I think that there is another issue, Chair. Kevin will pick up on this. I know that, among social workers and other disciplines, there is an issue with protected workloads with our students and all of that. Quite often, that goes astray and those students, in whatever discipline, are used as part of that model.

Mr McCabe: That is right.

Ms P Bradley: That is unacceptable for the client and, equally, for the worker. It worries me that, sometimes, when we look at figures and numbers, we are not seeing the full truth.

Mr McCabe: Yes, some of those figures are masked.

Ms P Bradley: When we are looking at the figures and how a community, of whatever discipline, has reduced, we need to look at all those differently. There are definitely faults within the system.

Ms Speed: I have to say one thing about that. Again, you could call it silo planning, but, honestly, there is only one area in which I have seen any attempt to manage that. A district nursing officer launched a review with the participation of myself, UNISON, the RCM and the RCN. The deficits in the nursing workforce, particularly in relation to TYC, really came to the fore. She has supported an argument for new post creation and funding. I think that will be pushed through. However, that piece of work seems to be disconnected. Some serious work is being done by Department of Health staff, so I would not like to give a totally negative view of that world. They did some good work, but it exists by itself; it is not connected to the broader process. At least, we do not know whether it is because we are not there. However, there was some planning at that level. Apparently, we have been given a promise that the 200 vacancies of community and district nurses will be filled. Funding is coming through, but we have not had sight of it yet.

Ms P Bradley: They have not given you a time frame on it, I assume.

Ms Speed: No, not that I am aware of.

Mr Swallow: Chair, just to comment on social work, I am very concerned not to see any serious consideration of client ratios in TYC. Last year, I saw the HSCB calling a market-sounding exercise on intensive family support, specifically saying that providers would have a low client ratio. The reaction

of social work trade union members, faced with the current high client ratios that they have now, was not particularly polite. I am pleased to say that HSCB has withdrawn that proposal. However, if we are to do serious planning in an area like social work, we have to focus on reducing the client ratio.

Ms P Bradley: I sometimes think that health professionals — I was going to say "we as health professionals" — need to look at unmet need, and not think of it as a negative, as such, for their profession. It shows the reality and truth. They should register that there is an unmet need because we do not have the staff to meet it. It is not a negative; it is always seen as such, but it is not. It is just telling the truth.

Ms Ronald: There is a tendency for health professionals to put the patient above themselves, and I think that you can see that in the rise in sickness absence levels that often mirror that. Staff are just getting totally burnt out from trying to do everything.

The Chairperson (Ms Maeve McLaughlin): Thank you. I am glad that the Deputy Chair keeps me on my toes: I should have declared an interest as a member of a union as well. *[Laughter.]*

Ms Speed: That is not a negative; it is a positive.

The Chairperson (Ms Maeve McLaughlin): Absolutely. I am a very proud member of a union.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thank you very much for your presentation and for coming today. I want to ask about the gender issue. The UNISON paper states that the workforce is substantially female and that there should be no stereotypes relating that fact to part-time work. Can you talk a bit more about that?

Mr Swallow: That is simply a reaction to what we hear as being stereotyped positions, particularly about the increased participation of women in certain professions, including the medical profession. We are concerned about any such direction. The statement is there for us to say, simply, that it is, above all, a female workforce and that we must not think that that can be exploited or manoeuvred in any particular way in the workforce-planning process. A full-time equivalent remains a full-time equivalent.

Ms McCorley: When you say "exploited", what does that mean? If the workforce is regarded as being substantially made up of women, how do you see exploitation happening?

Mr Swallow: The case study that we would first bring out is on the terms and conditions of the totally gendered home-care workforce in the independent and private sector, which, in many cases, is not even achieving the minimum wage. We have just managed our first successful HM Revenue and Customs (HMRC) intervention to get them back pay. They are faced with zero-hours models of contracts as a gendered female workforce, where, for example, they are disciplined if they go to work for somebody else when there is no work for them. Again, we have just won several cases on that: the exclusivity issue. Then there is the isolation and circumstances in which they have to work. Therefore, the contrast between a properly paid and structured in-house home-care service, which has about 40% of the work, and what is happening out there with this workforce that never seems to be included in workforce-planning processes in the private and independent sector is fundamental and seems to rely on gender stereotypes.

Ms McCorley: OK. Do you think that workforce planning at a departmental level takes into account the gender mix of staffing and the associated working patterns?

Mr Swallow: I think that we need to be at the table first. The whole content of the evidence today is not being at the table.

Ms McCorley: Yes. I agree. That is a huge issue. I agree totally that you should be there. This might be obvious, but why do you think that you are excluded from that process?

Ms Speed: I will repeat what I said earlier. It is either a misunderstanding of the importance of having trade unions as partners and not just as people at the end of the line — some distant stakeholder that you talk to three quarters of the way through the process — or there is a prejudicial view, which is that

we are really there only to solve problems rather than to contribute to solutions and be part of planning for the future.

Ms Ronald: Another problem is that, when you are not involved at the very earliest opportunity in making decisions, you tend to get stuck in a pattern of behaviour. We see the problems at the coalface, so we then have to confront them. You get stuck in what is almost a battle, because you are seeing it at the later stage. Therefore, I do not know whether we are perceived by somebody as being the troublemakers. If you are involved at that very earliest opportunity, you do not get to the stage of being in conflict.

Ms McCorley: You avoid it.

Ms Ronald: I think that that is the problem. We have been excluded from the process for so long that we have got into this conflict situation, where we are always seen by the Department as being adversarial. That is not where we want to be. It is where we have to be, because of when we are getting the information.

Ms McCorley: Moreover, people who work at the coalface have their ideas and contributions missed because they are not included in the discussion. Those ideas are so valuable.

Ms Speed: We on the trade union side — this is particularly true of UNISON, Jonathan — have been involved in partnership projects that arose out of a problem being identified, instead of us going into a room and having an argument about keeping the lines drawn, looking at the issue and asking how we can collectively contribute. We have had some good partnership projects; for example, the laundry services in the Southern Trust. That is an example that you might expand on.

Mr Swallow: The laundry was under threat of being tendered out and closure. We turned that around and put in a partnership. We made major improvements in staff welfare and health. We have better production, and we have even had the windows painted so that it is nice and attractive for nursing homes to bring us their laundry. Sometimes, partnership can be as fundamental as that.

The issue that I have difficulty with is this: if I look at the general practice of the Department of Health on equality, it is very poor. For example, a few years ago, under a different Minister, we discovered that its equality unit had screened 200 issues and screened out 200 from any assessment. That was a stunning bureaucratic process.

If members were to look, for example, at the recent departmental consultation on paediatric cardiology, on such a fundamental issue, they would find a tick-box equality model and four lines on human rights. If we are going to pick up on issues such as gender in workforce planning, it is incumbent on all of us, including the Department, to raise our game when practising equality rather than simply seeking to squeeze it out of the issues.

Ms Speed: Over the past seven years, and I have been involved in this field for four of them, the equality officers in each trust appear to have become less important, become less visible and been sidelined. When I first met a group of them four years ago, they had a hands-on engagement with trust delivery and strategic planning in the trust structures. That is not as visible as heretofore, so there are problems. It is like saying, "Sure, women have equality. What do we need to be talking about?" It is that kind of mindset. You need to be ever-focused on equality, because populations, people and practices change. You always need to have the mechanism in place to review and assess, and that has been downgraded.

There is no doubt that trust managements are under pressure to balance the books and to do this and not do that. At the same time, they have obligations based on the foundation and guiding principles of the NHS to make sure that none of this is lost in the mix. That is our general experience.

Ms McCorley: The issue was raised today and before about people doing work beyond the hours for which they are paid. Is there a tendency to see women doing that, or is it the type of work that more women are inclined to do?

Ms Speed: There are more women in the workforce, so, by that very fact, it would be women doing that.

Ms McCorley: Would that be as likely to be the case if there were more men?

Ms Speed: Sure, the world would change if there were more men doing it. *[Laughter.]* Let me tell you this: the living wage would have been well established — this is a personal view — people would not be existing on the minimum wage, and there would be a lot more done. It is in the nature of women who work in the health service, through their commitment, to care. I am not saying that men are not caring human beings, but by our gender we are. We tend to commit and give good measure and show a high level of participation in and commitment to our work.

A few academic exercises and bits of research show that the public sector generally delivers better equality than the private sector on a gender basis, so we would guard our public-sector employment very closely. It is important for women in this part of the world that they continue to work in the public sector, because it gives better support to them, and women give better commitment to the public sector.

Ms McCorley: You expressed concerns about a move towards privatisation. Do you feel that that —

Ms Speed: Let me tell you, as the lead negotiator for trade unions in the bargaining structure, that all trusts have shifted from a predominance of direct delivery — for example, in domiciliary care — to a minority ratio. That is very serious. The drive to continue that is underpinned by the balance-the-books directive from the Department and the trust deficits. The difficulty is that the conditions of the women working in the private home-care sector, as Jonathan said, are 50% of what the women workers have in the health sector. There is no minimum wage and no mileage. You do your 15-minute call and appear 5 miles down the road two minutes later.

The drift towards privatisation is very worrying, and I think that the Assembly, and all political parties, could make a huge contribution to stopping that drift. We could play a leading role here in defending the NHS and making sure that it is not deconstructed in Northern Ireland, no matter what happens elsewhere. Colleagues in Scotland and Wales have a bit of a fight going on as well. It is very serious. That is why I mentioned the decision in the Assembly some time back. You have a mechanism to review it and look at it. Jonathan, do you want to add something?

Mr Swallow: Just a very quick comment. To give an example relevant to the scope of the Committee but outside of health, the Fire Service is now tendering out the jobs of the 50 women who get four hours a week to clean the volunteer fire stations. There are no savings there. It is a bizarre proposal apparently to rationalise cleaning, but nobody appears to have done an equality impact assessment (EQIA) and nobody has looked at impact. Those women will be extraordinarily vulnerable under any privatisation. The HSCB is currently tendering the work of a number of offices outside of trusts, including subcontracted cleaners, and it is taking no steps to ensure proper transfer of information to potential tenderers. Again, we are going to organise those women, because they are in a terribly vulnerable position. If we look at the whole range of contracting, we find subtle ongoing processes of privatisation that affect the most vulnerable in society.

Ms Ronald: There is also fear because we are further removed from the decisions being made. When you see changes happening to services, the fear is that those changes are ultimately setting them up so that somebody can come in and take that portion of the service.

Ms McCorley: Yes, they are being packaged.

Ms Ronald: Yes, the way in which they are being packaged. There are other things coming to the fore that could be causing concerns on that.

Ms Speed: I heard reports just today that something may be happening in medical laboratories. Our colleagues who work in that field shared that news with us today, so we will have to watch that space. No doubt we will bring it to your attention if it comes to the fore.

Mr McGimpsey: Thanks for the presentation. I am sorry that I missed the beginning of it. It was quite sobering. We had something similar from the BMA, the RCN and the RCM, so things are far from easy.

I will talk a wee bit about the structures shortly, but, from my experience, the Department is not there to run the health service. That is not its job. The Department and the civil servants are there doing

their job, which is policy, supporting the Ministers in questions, debates, and so on, and managing the money that flows from the Department of Finance down to the trusts. The key instrument for managing all of that is supposedly the Health and Social Care Board. There is supposed to be a trade union representative on that board. It was Lily Kerr. Who is it now? Is it nobody now?

Mr Swallow: There is no non-executive director from a trade union background.

Mr McGimpsey: A vacancy is still sitting there, is that right?

Mr Swallow: There is no vacancy. It has been filled elsewhere.

Ms Speed: The previous Minister, Mr Poots, filled that vacancy with somebody from the financial sector, I think.

Mr McGimpsey: The key thing is that this is a team game, as we are all aware. Everybody is on the team. On the board, we have a doctor, a nurse and a pharmacist, and we had a member from staff side. It is just —

Mr McCarthy: How did you let that go?

Ms Speed: We did not let it go. We objected and raised complaints, but sometimes you are talking to people who do not want to hear you.

Mr McCabe: As a side issue and for the record, my organisation had to take a judicial review, and the judge ruled that the Minister had acted unlawfully in not appointing a trade union nominee to a trade union seat on the Northern Ireland Social Care Council (NISCC).

Mr McGimpsey: OK, but you still have representation on the Public Health Agency.

Mr Swallow: Yes.

Mr McGimpsey: And the Business Services Organisation (BSO).

Mr Swallow: The term of office is about to come to an end. We are very nervous about whether either the individual's seat or the trade union seat will be renewed.

Mr McGimpsey: Thank you for that. It was for my own information.

The key thing that you are saying to us, Jonathan, concerns the unmet need. What is the unmet need? It is people in pain and distress and coming to harm. Those are patients who are falling through the net. The other key thing that you ask is how many people are needed to do the work. It is an issue, because you have to have the workforce in place to meet the demand as it reaches you. Have you any sense of where we are at with the workforce, from your side of things? We have heard from the BMA, which is very, very nervous; we have heard from the RCN, which is very, very nervous; and we have heard from midwives who, again, are very, very nervous about the current situation and what is coming. It seems to me that the first thing that we have to do is to get a bit of stability. We need to stabilise the situation before we take ourselves back to where we want to be. Have you any sense of where you are at with the workforce?

Mr Swallow: I think that the first precondition is to have a stable financial platform that is measured against need. We have not done that, and the tendency is increasingly not to do that, and that causes us great concern. We also need confidence-building messages in the workforce rather than saying that they are the problem. For example, when every trust is meeting the Minister's sickness target, the immediate approach is to say that we want to get even less sickness. We have done really well on that, and we are not celebrating such achievements, where every trust is within the Minister's sickness target.

Obviously, we need this process of modelling and workforce planning, with trade union input, but it needs quick moves to some proper ratios and staffing models that are not there. The one, of course, that we would highlight today is the absence of progress on normative nurse staffing, which is a critical safety issue in wards. We have the guidance of the Chief Nursing Officer and that of the National

Institute for Health and Care Excellence (NICE), which, in my view, is much more rigorous and better, but we are not applying that guidance. The reports that we get are of notes of concern under the process effectively being ignored. Members are telling us that they put in the AI notes, and nobody ever comes back on them. We have even had to set up courses, as UNISON, to teach our members the law of whistle-blowing. That is the ongoing issue that we now face.

Mr McGimpsey: That is unsafe staffing levels — of nursing staff — on wards, which, by definition, puts patients at risk.

Mr Swallow: Yes.

Ms Speed: I could give you a confidence-building measure on that that could be undertaken, which is to pay the staff their pay increase, and pay them, as per minimum, the pay review body's recommendation, and not slavishly follow what the Tory/Liberal Democrat coalition undertook in England. We are now the worst. I think that we are in the poorest position across the four jurisdictions in the NHS. That will not be resolved here, but any influence that you can bring to bear on those who hold the purse strings — the Department of Finance and whoever is managing the Department of Health at the moment — would be helpful. It is very important, because, believe you me, the morale of the workforce and its annoyance is increasing and accelerating. There is a measure.

Mr McGimpsey: OK. I would not disagree with that. In fact, I agree strongly with that.

As far as the Department's finances are concerned, however, the 2011 Budget massively undershot what was required to provide for the need. It was, as I recall, about £4·8 billion, but £4·5 billion was delivered. That was clearly not enough, and, as a consequence, we do not have a large enough workforce to deal with the need, and, as such, we are getting large amounts of unmet need. The longer that this goes on, the worse that it gets. Where are we now with the Department? I understand that we are back into the situation of overspends and drastic action being taken to get our budgets into line as opposed to getting our sick people into line.

Ms Speed: We are still £80 million adrift.

Mr Swallow: The system started this financial year £31 million in deficit. One of the trusts has a £7 million deficit, which will have to be rolled forward into next year. One of the trusts actually made £2 million, which was immediately taken away by the Department to meet medical negligence claims. The system is starting in deficit, and it will be worse because of the failure to meet the savings targets that I referred to earlier. That takes us up to £60 million. We saw this pattern last year of escalating deficit and of trusts being in deficit, because it is very clear that each of them is headed for substantial deficits by the second quarter.

We cannot just go on relying on monitoring rounds and sticking plasters to keep this going. It is fundamentally unstable, and, as indicated earlier, the HSCB non-executive directors shared our view at the previous meeting that we are on the cusp of risk and of compromising patient safety. It is time not just to take radical action on the structures but to rethink the financial platform, not only to deliver what we do now, which is done under pressure, but to deal with unmet need and fundamental health inequalities. We were very concerned, in the most recent ministerial direction, that the detail of the previous one about the specific actions to reduce inequalities had been removed. It was just a statement about health inequalities, full stop. We do not appear to have a strategy linked to finance and performance to get those three issues right together.

Mr McGimpsey: OK. Thanks for that. The key instrument for management is the Health and Social Care Board. That is what it was set up for. I set it up, so I am guilty. I brought four boards into one, and that was to be the key instrument. I said that, under no circumstances would we go over 400 with that management, and when I left it was 352. I understand that it is now 525, and it seems to be loaded. How effective is the board now? The deal was that the Department would come out of running the health service. The Civil Service cannot run a health service. Therefore, you have to have a management function. The board was to be the management function that would take the burden off the trusts, allowing you to reduce management functions in the trusts and more money to go to the front line. How effective has the board been? You can give me an honest answer.

Ms Speed: We debated this earlier at the start of the meeting, but we will repeat what we said.

Mr Swallow: I would draw your attention to the York University evidence, which shows that this sort of system can generate up to a 15% overhead on the unit cost of a treatment. What we have at the moment is the Donaldson review. We have the Department's review of commissioning — I gather that the chief executive of the HSCB has just been shown the terms of reference — the HSCB's own review of commissioning and the Department's review of administrative structures. In Russian, the word is "maskirovka", which means "distortion, deliberation and confusion". It is a masquerade. We will not address the fundamental issue of how we commission and deliver services with the current disparate review process. That process has to be challenged. It is not time-limited; it is taking the issue away into the comfortable world of having reviews.

Ms Speed: It is about having one self or one structure, instead of somebody or a body or instead of a review being taken of the whole service. We thought that we were getting somewhere with that conversation, not with the Minister who has just departed but the one before. There is an awful lot that we would disagree with him on, but the one thing that he did not do was sign off on the budget, which was in crisis. Perhaps I was talking to you at the time. I am not sure.

Mr McGimpsey: Sadly, no.

Ms Speed: He did not do that. That kind of momentum around looking at the big picture seemed to dissipate. The directive then came down to balance the books. There was a scattering. We got all these decisions to cut cloth to suit measure. The crisis actually deepens.

Mr McCabe: May I make two observations? Obviously, the establishment of the board was broadly supported as part of phase 2 of the review of public administration (RPA). We wanted to see it fit for purpose. I have observed that the difficulty that you then have is that the Public Health Agency is there to commission services on behalf of the population and the board is there to do the commissioning plan. It sends the plan up to the Department, and the Department says, "We do not have any money". We are seeing this cycle being effected. Equally, the other most important point is that, if you remove commissioning from the board, someone still has to do it.

Mr McGimpsey: You see, that is not actually how it is supposed to work. The Public Health Agency is not there for commissioning.

Mr McCabe: Observations.

Mr McGimpsey: It is supposed to be the board doing that. Effectively, the board tells the trust, "Here is what we need you to do, and here is the unit cost", and so on. This is not rocket science. You know roughly how many hips you will need, and you know how much that will cost. You know how many hearts and domiciliary care packages you will need. That is what the board is there to do. We did away with four boards and got one. What I am detecting from you is that the Department is still at the old business of trying to run the health service and overrunning the board, and the board does not appear to have the authority that it should have over the trusts. Therefore, there is general confusion, and everybody appears to be chasing their tail. It appears to be fairly confused.

Mr Swallow: I have attended the past 14 public meetings of the Health and Social Care Board to find out what is going on. I am the only member of the public present. Nobody engages. Sometimes we take speaking rights to try to change things.

Mr McCabe: I was with you in December.

Mr Swallow: Yes, I agree. *[Laughter.]* There were two of us present at that Health and Social Care board meeting. It has no resonance with people. It has no resonance with confirmed organisations, when it is the decision-maker on commissioning. That absence of resonance is leading to such frustration out there among all the organisations and groups that seek to improve health care. We are actually training up the Bangor protest movement to address the next meeting. We think that those meetings need livening up a bit.

Ms Ronald: If you want to see how effective the board is, you need to look at what it was set up to do and then consider the delay with everything. It comes back to that commissioning provider split that we have this dilemma that we often do not get a commissioning plan. I think that the worst delay that we have had was almost a year.

Mr McCabe: It was over a year.

Ms Ronald: How can you deliver a service?

Mr McGimpsey: You cannot.

Ms Ronald: You have got trusts trying to continue to deliver without knowing what budgets they are getting, because they have no commissioning plans. Even now, we will not have the draft commissioning plan until next month. We are already a month into the financial year. We are already behind in the process.

Mr McGimpsey: Reading between the lines, what the board is doing is waiting to see what money will be available to add to the commissioning plan. Then, as you are saying, you are commissioning according to money and not according to need. That is why it is late.

Ms Speed: I would make the observation that you always need to have the Department that has responsibility on the part of the legislature to oversee the service. What you have with the Health and Social Care Board is a big bureaucratic structure, as distinct from a function. There is a debate to be had about housing that function much closer to the service providers, which are the trusts.

Mr McGimpsey: It is supposed to be like that.

Ms Speed: When I first came to work in UNISON, I kept meeting people who were directors of this and directors of that in one room. I then went into another room, and there were directors doing the same thing, but they were at the level of the service. You had duplication and a structure that has grown, as you indicated by your comment, far beyond the original intention. The function of commissioning must always be there, but it is about how you construct that. We now have a bureaucracy.

Mr McGimpsey: And you start with need.

Ms Speed: It costs too much.

Ms Ronald: There is an added layer because of the extra bureaucracy that TYC added.

Ms Speed: More people were appointed and some were paid out of the £25 million. I did not know what they were doing, but there you go.

Mr Swallow: Just to amplify the point, the PHA has recently been through agony to meet the departmental call for a 15% budget cut — intense debates. The HSCB, in a finance report lasting three minutes, handed 15% back to the Department without blinking. Something is profoundly wrong with the balance of funding in various parts of the health service.

Mr McKinney: Michael made the point last week that there is an emerging picture. Normally, when you look at these things, you expect stakeholder criticism, from their perspective, on the production line, but we are hearing from all the stakeholders that the production line is bust, if that language does not undermine it. The stakeholders view the system as broken. From your last meeting with the board, what is your interpretation, in the context of our discussion, of how it marked TYC to now be at green or, in other words, doable?

Mr Swallow: The member who replaced the trade union member quite rightly asked some very challenging questions about us having gone from amber to green, particularly when the unit was to be broken up, the post holder not replaced and the whole function moved elsewhere with minimal investment. There was good criticism from non-executive directors. At the end of the day, the non-executive directors on that and the trust savings required the board to write to the Department to express concern. The green designation was seen as quite extraordinary, and you could see the looks around the room.

Mr McKinney: I want to interrogate the point about the TYC group being split up. Is it your understanding that that is going?

Mr Swallow: Yes, the unit is to be restructured, to use the euphemism. The function is to be mainstreamed into the work led by the director of commissioning. The general commissioning process, including the commissioning plan, is now to include TYC. Under pressure from the non-executives, there was an agreement to continue with what is called the TYC highlight report, which is about where things are or are not — usually not. As I said previously, I await with interest the report on where we are with the 99 original proposals.

Mr McKinney: What does that say to you about the last three and a half years of being persuaded about TYC?

Mr Swallow: We have been trying to achieve something that we are not funded to achieve. There has not been the hard realism that I would have expected — I may not have approved of it — in the project. Liam Donaldson is absolutely correct in saying in his report that there has not been the pressure or the drive to deliver. Maybe the sanitisation of targets, as I referred to earlier, is part of a sanitisation strategy to make it appear that we are moving forward. We all, including union members, have to acknowledge how desperate the situation is and the need for fundamental other directions in which to move forward.

Mr McKinney: So has it been a bit of activity disguised as movement?

Mr Swallow: Particularly in respect of the integrated care partnerships. We have still not had a response to our request to see the plans for the ICPs as approved by the board.

Mr McKinney: We have asked two or three questions on that and still cannot get an answer. We get some general headlines about what they are all at. With no drive and, based on what you are saying, I suggest, no plan, how do we transform the health service?

Mr Swallow: I suggest that we start with inequalities, as I indicated earlier. We identify the unmet need and match that with the existing need for performance and care, and we match that with a sustainable financial platform.

I looked recently at an outstanding piece of work by two economists David Stuckler and Sanjay Basu. 'The Body Economic', provides the most convincing evidence, passed down over the past 100 years, that if you have a crash or a recession, you either pump-prime — I dare to use the word "Keynesian" — direct health care or you do austerity. 'The Body Economic' provides compelling evidence that austerity damages health and causes health inequalities. It appears that that compelling evidence — the book was published three years ago — is being ignored by policymakers and governing politicians at all levels of the UK.

Mr McKinney: OK. I had a specific question, but it disappears in the midst of that big strategic thought. We are at pivotal moment here. The Committee has got to take all of this seriously. We have to sit down and assess where this whole process is going. TYC somehow does or does not exist, and we have no measurement. Those are the questions that we asked at the start about this: where was the measurement, the implementation and the money? They spent a year or 18 months trying to pretend that there were measurement, implementation and money, and clearly those have not been there. We have wasted another year and a half. I just think that the Committee has to reconfigure some of its approach around this, to interrogate the Department about where it plans the health service to go.

Ms Speed: I remember being in a room when we first heard presentations on TYC, and I asked the permanent secretary at the time whether this was the "Lansley Act", to which he said: "Absolutely not". Then we got the document and it was just as though somebody had taken that approach to the NHS, looked at the financial difficulties, put the two together and landed on top of Northern Ireland this view of how the health service should be developed. We are dealing with the fallout from that and resultant crises.

I repeat that, with all the good will toward the health service across all parties and interests in this place, we could come together and do something different here. In conjunction with us and other representative organisations, something different could be done to rebuild on the founding principles of the NHS. A big transition is going on across the water, but it is open to serious challenge. Sure, the whole election process there is revolving around what happens to the NHS. It is the issue of the moment; you are quite right, and I think that we could do something fairly significant and innovative

here. We could work together. We are up for it and willing to do it, and every staff representative organisation that came before you and gave evidence is of the same mindset as we are. We could look to models elsewhere in the devolved nations and see what we can do.

Mr McKinney: Based on the factual evidence and not just the evidence as presented, this job is too big for the Department.

The Chairperson (Ms Maeve McLaughlin): There is a pattern. All of the evidence that we have heard to date has been similar. There are clear challenges. When you hear things such as the risk to patient safety, the amount that was taken back from trust savings plans, as they are called, and delivery plans, I think that we are at the stage where a hard conversation must take place about what we need to move towards a public health model that targets health inequalities. We need to discuss what system is required to do that, because it is very apparent that it is not the current system. As I said in my open remarks, the present system is not configured to deal with our society's existing challenges and need. Rest assured of this: on the back of evidence that we have heard today and previously, and will hear in the next weeks, we will reflect on and draw up recommendations for clear actions.

There are a number of actions that I have noted down. I would have thought that a vehicle like the partnership forum would have been the model to have that hard conversation in relation to the type of model that we need. So, it is time for delivery on it. Thank you all for your attendance and participation. We will keep the conversation going.

Ms Speed: Thank you for the time. You gave us a good airing today. We appreciate it. If I may be so bold, I will leave some reading material.

The Chairperson (Ms Maeve McLaughlin): Absolutely.

Mr McCabe: Sorry, Chair, I missed the deadline for the NIPSA submission, for which I apologise. There are copies here, or I am happy to send them to the Clerk.

The Chairperson (Ms Maeve McLaughlin): OK. Do you want to leave some copies here? We can circulate them. OK, members. Thank you for your attendance.