Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

June Monitoring Round and Forecast Out-turn for 2011-12: DHSSPS Briefing

30 May 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

June Monitoring Round and Forecast Out-turn for 2011-12: DHSSPS Briefing

30 May 2012

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

Witnesses:

Ms Catherine Daly	Department of Health, Social Services and Public Safety
Dr Bernie Stuart	Department of Health, Social Services and Public Safety
Ms Julie Thompson	Department of Health, Social Services and Public Safety

The Chairperson: You are all very welcome. Thank you for the briefing paper that you provided to the Committee. I do not know who is taking the lead, but we have a tight session today, so I will hand straight over to you.

Ms Julie Thompson (Department of Health, Social Services and Public Safety): Thank you for the opportunity to provide evidence to the Committee today on the forecast out-turn for 2011-12 and our participation in the June monitoring round for 2012-13. Re the forecast out-turn for 2011-12, you will be aware from the Minister of Finance and Personnel's statement yesterday that Northern Ireland Departments delivered a total underspend of some £68·5 million in current expenditure budget and £30·1 million in the capital budget. Within that, our Department's current expenditure underspend was £13·1 million, or 0·3% of the total budget, and £1·1 million in the capital budget, which is 0·5%. That reflects a slightly more up-to-date current expenditure underspend compared with the £12·7 million in the briefing paper, so it has moved slightly.

Those are exceptionally low percentages, which continue the strong performance in this area in recent years and on which the Minister of Finance and Personnel commented favourably yesterday. Notwithstanding that, the delivery of financial break-even was not easy, and, as the Committee knows, it required a wide-ranging reworking of plans and savings proposals across the budget.

As we have said to the Committee previously, the balance position has not been without implications for services. Budgetary constraint has meant, for example, that waiting times remain too long in some

specialities, and there is a noticeable divergence from the quality of provision elsewhere in the UK. The challenge faced in 2012-13 is no less significant, and, in that context, we are committed to maximising the use of resources and to early planning with our board and trust colleagues.

I think that it would be helpful to recap some of the key aspects of the June monitoring process. First, we have been granted certain flexibilities in the management of our budget that are not available to other Departments. Those include the automatic retention of reduced requirements and the full flexibility to reallocate reduced requirements across our budget. Those flexibilities mean that, when it comes to monitoring rounds, our participation is different from that of other Departments: we are not permitted to table bids for current expenditure, except in the event of major and unforeseen circumstances, and we are not expected to declare reduced requirements. Secondly, as the Committee will be aware, any allocations made through monitoring rounds are typically non-recurrent in nature and must be used in the current financial year.

I will now outline the proposed approach to current and capital expenditure bids. In determining our approach to current expenditure, we considered a range of factors, including the financial context for 2012-13. The assessed scale of financial pressures in 2012-13 amounts to some £226 million. Learning from the performance and efficiency delivery unit (PEDU) review and the independent peer review undertaken by Anita Charlesworth, the board and trusts have been working closely to identify opportunities to deliver savings and address those pressures. In that context, we have identified savings opportunities of £185 million. However, that still leaves a funding gap that we are working hard to address.

In addition, given the significant level of savings that we are already required to deliver, we also propose to submit current expenditure bids totalling £40 million for two key initiatives: £18 million for transitional funding for Transforming Your Care (TYC) and £22 million for elective care services. Our assessment is that it is just not possible to fund those bids from existing budget allocations without having a detrimental effect on the quality of services for patients and clients. The TYC report estimated that some £70 million of transitional funding would be needed over the next three years to pump-prime those initiatives and make the key transformational changes.

The £18 million bid for the transitional costs for 2012-13 would help to ensure the delivery of the first stages of the wide-ranging systematic changes envisaged in Transforming Your Care. The resources would be invested in the establishment of integrated care partnerships and in supporting the implementation of necessary service changes, including the management of workforce implications. Any significant service changes would, of course, be subject to appropriate public consultation.

In elective care, additional investment is now needed to improve performance across a range of regional specialities, including orthopaedics, ophthalmology, general surgery, dermatology and gynaecology. Our assessment is that each of those bids can be considered as both major and unforeseen in the context of the June monitoring round, and, as such, we are permitted to submit them.

As outlined in our briefing paper, the Department proposes to submit capital bids of some £20·5 million. The focus of our capital bids has been to identify those projects that require urgent infrastructural work and can be procured and delivered before the end of the financial year. In that context, the majority of the capital bids relate to a range of smaller projects, including maintaining existing services directed towards life-threatening and high-level risks, such as infection control and fire risks.

In conclusion, given the current funding shortfall and significant savings already required to be delivered in 2012-13, our assessment is that it is not possible to fund those additional pressures from within existing budget allocations. The Transforming Your Care transitional costs and the elective care bids will help to secure the necessary reforms in health and social care services and significantly reduce access times for a considerable number of patients. We strongly recommend that those bids are considered favourably by the Committee and Executive. We are happy to take members' questions on any of the issues that I raised.

The Chairperson: Julie, thank you. I have a number of questions, some of which look for more information, which you probably do not have with you today, but I am happy to wait for it. Your briefing paper refers to arm's-length bodies, and it might be useful for us to have more financial information on those. Also, the Committee has taken a keen interest in the reduced costs of clinical excellence awards, so it would be useful to have a further breakdown of those. May we also have a breakdown of the underspend in the Department's administration budget? That would be useful.

I am a bit confused about the paper's proposed solution to manage the funding gap. The briefing paper states that savings are being made. Later, we are told that there are pressures. How does that work?

Will you also give us more information on some of the surgical issues? A number of years ago, the money put into dealing with waiting lists seemed to have an impact. Do we now need additional money to target waiting lists?

Will you answer those questions first? You will be glad to know that I have a couple more.

Ms Thompson: I am happy to provide the details that you asked for. We have draft accounts for all our arm's-length bodies, and the level of underspend in each can be provided to the Committee. The underspends are all relatively low and operate below about £200,000 per body. I am also happy to provide the details on the reduced costs of clinic excellence awards and the departmental running costs (DRC) budget.

In the briefing paper, we outlined the extent of the pressures that we face to the Committee as we see them and as we do every year. Those pressures range from pay and non-pay to the fact that the population is getting older. We log those as issues that, effectively, cause increased need or increased pressure on the budget. We then list some proposals for savings that would help us to meet a large proportion of those pressures. Although that does not square totally at this stage, we are working hard to make it square, so that, ultimately, we will have proposals to match the extra pressures that we will face in 2012-13 and get us back to a break-even position. We are happy continually to update the Committee as we work through the financial year.

Catherine will set out the position on waiting lists.

Ms Catherine Daly (Department of Health, Social Services and Public Safety): Waiting lists have been increasing since mid-2010. Currently, across all specialities, 120,000 people are waiting for assessments and 50,000 for treatment. From our work with the board, our estimate is that, without additional funding and despite all the actions that the board will take with the trusts, at the end of this year, 67,000 people will be waiting for assessments and 15,000 for treatment. That is still a major issue, which is why Julie said that it must be logged as a major pressure with the Department of Finance and Personnel (DFP).

The specialities for which we are bidding are orthopaedics, ophthalmology, general surgery, dermatology and gynaecology, because those are the areas in which there is the biggest demand and the highest increase in waiting lists. The board's work on a demand and capacity analysis shows that those are the areas in which there is the greatest gap in capacity. The £22 million that we have bid for would address those backlog waiting lists —

The Chairperson: Where is that going? How will you deal with that? Will that money go to pay new people to come in and reduce waiting lists?

Ms Daly: Services would be provided by the trusts and, perhaps, by the independent sector. It is about where the required services are available. Obviously, that is set in the context of value for money, which is a key consideration for the board. However, the prime focus is on reducing waiting lists so that we can concentrate on delivering the Minister's targets. His waiting list targets are aligned to ensure the delivery of safe and effective services. Therefore, Chair, the answer is that it will be a combination of areas.

The Chairperson: We will come back to that, but my concern is that, for example, a specialist might see 30 patients on a Tuesday and 30 patients on a Thursday. However, when paid additional money, he or she can see 60 patients on a Saturday. We need to be careful that that does not happen again. As much information as possible needs to be given to the Committee on that. You are talking about value for money, but why can those 60 patients not be seen on a Tuesday or a Thursday?

Ms Daly: Absolutely. That is where the board's work on the demand and capacity analysis is critical. The board is working with the trust to determine what their capacity should be and where there is a gap between the level of demand and the capacity to deliver. That will inform where those services should be provided. That is fundamental to your point, Chair.

The Chairperson: Under staff productivity, is there any suggestion of redundancies?

Ms Thompson: As part of the Transforming Your Care transitional costs, there is an expectation of an element of voluntary redundancy. That would be targeted while necessary service reforms connected with TYC were taking place. The targeted efficiencies are managing sickness absence, looking at agency costs and that sort of area, as opposed to redundancies. However, redundancies would be part of the picture of the Transforming Your Care transitional costs.

The Chairperson: Transforming Your Care seems to be the thread that runs throughout.

The paper refers to social care and reform. I have heard that care homes for the elderly in the independent sector do not know what will happen after next year and that no negotiations are taking place with the board or the trusts. Further on in the paper, you suggest that, if you do not get the money for Transforming Your Care, reform will be delayed. Therefore, we seem to be putting the cart before the horse, in the sense that the Compton report states that more people need to be at home — there are positives and negatives to that. However, why is that happening now with the independent sector? It feels that it is not being told what is in store for it further down the line.

Ms Daly: I will pick up on that. I am not familiar with the particular issue, but the key initial deadline for moving forward Transforming Your Care is the production of population plans by the end of June. Those plans, by their very nature, will determine where services need to be delivered and where service changes will happen. Until the population plans are produced, there is a limit to the extent to which Transforming Your Care can be taken forward. However, the importance of engagement and communicating with people so that they know what is happening is fundamental.

There will be consultation on the population plans and on key changes emanating from them. I do not know whether that fully answers your question. The Minister is clearly focused on the importance of communication and has made that point a number of times. It is fundamentally important that people understand what changes are happening, why and how they will be affected. The intention, therefore, is that there will be full and effective engagement. However, it is acknowledged that, until the plans are produced, there is a limit to the extent to which that can happen.

The Chairperson: I have a number of further questions, but I will bring in other members. If my questions are not covered, I will come back to them at the end.

Mr Wells: First, I think that congratulations are in order. Given that the health budget is something like £4·5 billion, getting your underspend to within 0·3% is quite extraordinary. Well done. That is very helpful, particularly when you had to find considerable savings to get to that stage. I do not envy you having to start again and find another raft of savings this year.

I wanted to set that context before making my next point. At the end of the year, when you realised that you had £13 million, was there no little pet project, vehicle or piece of machinery that could have been bought off the peg? That may sound simplistic. Anti-TNF drugs, for example, can be bought almost instantly, have a two-year shelf life and a considerable backlog of people waiting for them. Have you nothing on which you are ready to pounce that would eke out that last £13 million? In health services budgets, that is almost nothing, but it sounds like quite a lot of money to the public.

Ms Thompson: In balancing the budget, we must always be careful not to overspend. That £13 million is 0·3% of the £4·4 billion budget. If we were to buy anything more, we could, potentially, be at risk. We still have to work through draft accounts and get them all signed off, so it would be exceptionally difficult to push that even further.

The other point that I would like to make is that the £13 million that we returned to the pot comes back through into 2012-13 at the Northern Ireland block grant level, as the Minister of Finance and Personnel explained yesterday. That allows some of the funding to be freed for the likes of the June monitoring round. As I understand it, overall, £46·5 million will come back through into 2012-13, and that will provide a source of funds to help to produce extra services during that year. To that extent, the £13 million is not lost.

Mr Wells: It is not lost, but, presumably, you would get back only about 40% pro rata.

Ms Thompson: The amount that we get back will be determined by the Executive in June monitoring and by the bids that we put on the table.

Mr Wells: As far as last year was concerned — I am just nit-picking to be honest with you — I thought that you might have a fleet of ambulances waiting outside and you could say, "I'll have that one, that one and that one". Obviously, it does not work like that.

I presume that, in 2011-12, in medical terms, you picked the low-hanging fruit. Have you any thoughts on where you will find the next tranche of savings? Although you have extra resources on the medical side, the demand, of course, constantly increases at a much greater rate. Now that we are nearly into June, how is it looking?

Ms Thompson: We looked across the board at where savings might come from. Across the trusts, and through pharmacy and other means, we have identified £185 million of savings. Those come from a whole range of initiatives right across the board: the acute sector, social care, procurement, discretionary expenditure and pharmacy. All those are part of the mix. Therefore, you are right that, as we go into each year, we look again at what we can do to balance the books. The required savings run at more than 4% of our budget and are a challenge to deliver. The plans are still being worked through and finalised, but the savings are of that order. Savings of £185 million do not quite square the books, so we still have to do more. We are working hard to sort out the final bit and will work through the process during 2012-13. I will come back and update the Committee regularly on that.

Mr Wells: Have you built into that an assumption of a certain figure in the monitoring round, or will any money from the monitoring be extra and additional?

Ms Thompson: It will be extra and additional. Our bids in the monitoring round are on top of what I have described. Therefore, if we get extra money for elective care, that will be on top of what we have already, and it will allow us to do more than what we factored into the budget. If we get the money for TYC, that will be on top of our existing budget. That is all additional.

Mr Wells: Where is the money to implement the Compton report? Is any of that built into the 2012-13 year?

Ms Thompson: No. That money is a bid to the Executive. If that money is not received through June monitoring, it means either that the money to pay for implementation will have a detrimental impact on what we had planned to do with the rest of our budget or that things will move more slowly than we had originally anticipated. All the money for implementation is on top of the existing budget assessment that I described.

Mr Wells: In response to a question from the Chair, you mentioned redundancies. Are we still talking about voluntary redundancies?

Ms Thompson: Absolutely.

Mr Wells: So nothing in the figures in your briefing paper indicates compulsory redundancies in 2012-13?

Ms Thompson: They are not being planned at this stage.

Mr Wells: That is good news.

Mr McCarthy: I will follow on from what the Chair spoke about, namely social care reform. We are all aware of the rapidly increasing need for high-quality social care, which is borne out in the Compton review. What we have heard up to now is that it is all about Transforming Your Care, etc. I would like to ensure that the savings listed under social care reform on page 18 will not take away from access to high-quality social care for all our senior citizens or older people. There are four issues there. Will you talk us briefly through planning, price negotiations, savings and management? In reply to the Chair, you spoke briefly about the independent sector and community care. Will you explain those four issues to make them a wee bit clearer for us?

Ms Thompson: The social care reform is very consistent with the Transforming Your Care recommendations and proposals. It is all about ensuring that people are treated in, and remain in, their homes as much as possible. That is what the re-ablement initiative is all about. It is about avoiding people having to go into hospital and ensuring that, when they come out of hospital, they go back to their homes, maybe through some sort of intermediate care arrangement, rather than into a long-term care facility.

We look at every price negotiation right across the board. All services are considered to see what can be done with the costs and to ensure that they represent value for money. Like everything across the budget, management and administration is being targeted to see what we can do to reduce those costs. We try to ensure that, as far as possible, people are in the right settings for the services that they require. As Catherine explained to the Chair, the right setting, as far as possible, is back in their own home with the support mechanisms around them. If that is done in the right and appropriate way, we should be able to get a win-win situation of better care for the patient and savings against the Budget.

Mr McCarthy: That is fair enough. I am just a bit concerned that, in response to Mr Wells, you said that, if you could not get this money in the June monitoring round, there could be question marks over the whole Transforming Your Care programme. That worries me. It is easy to talk about these things but it is about putting them into action, and there is no guarantee.

Ms Thompson: No, there is no guarantee. However, at the moment, the £18 million that we are bidding for is not factored into our Budget assessment. As I said, if we do not get the money in June monitoring, you either bring that in as a pressure and say that you have to cut something else to fund it, or you do not do it at the pace that was proposed originally. That is what is behind the bid.

Mr McCarthy: So, right from the word go, Transforming Your Care and the Compton report is really a gamble. We all think that it is good on paper, but we are not so sure about putting it into practice, are we?

Ms Daly: We are absolutely clear about the benefits to be had over time from putting it into practice. It has been recognised clearly from the beginning that there would be transitional costs associated with that. Those transitional costs are £70 million over the whole Budget period. This is a major change that affects every part of health and social care services. We need to take it forward in a way that allows services to continue to operate at the same time as transition. That cannot be done without some assistance, because you will have some parallel and transitional running during the process. It was always recognised that there would be costs associated with implementing this change, and that is the £70 million. Inevitably, as Julie said, if we do not get the additional costs, it will impact somewhere. These are real costs, so it either means that something else will have to be reprioritised or that this will not move forward as quickly as planned.

Mr McCarthy: So, we cannot guarantee that our elderly people will get the first class social care that they need. You talked about the cost. Last week, we were talking about the cost of using outside consultants to give us population plans. In my opinion, population plans could be done at a much cheaper rate within the Department.

The Chairperson: Well done, Kieran.

Ms Gildernew: That leads me nicely on to my first question. You are very welcome. Last week or the week before, we had a session with John Compton and the permanent secretary about the population plans and the amount of consultancy spend. The more I think about the population plans, the more I think that they are a stick to beat us with. In the Western Trust area, the population is sparse and getting sparser every day as people leave this country to look for work around the world. My fear is that, when the population plans are devised, services may be removed from an area because the population plan does not point to them being cost-effective, and I worry about the impact that it will have on the delivery of healthcare services in areas such as my constituency of Fermanagh and South Tyrone. I am very concerned about how that will pan out and what decisions will be taken. Is there any thinking in the Department to move in the way that the British Government did a few years back when they realised that, if they did not do something to protect some post offices, the rural system of post offices would disappear entirely? They had to say that, although a post office might not be cost-effective when looking at it on a spreadsheet, it provided a valuable service to people in that community and, therefore, they had to subsidise it. Is there thinking in the Department to ensure that

people have access to quality healthcare, or will people in areas that are sparsely populated be left behind?

Ms Daly: It sounds like we say this every time, but we cannot determine everything until the population plans are produced. However, the key focus of Transforming Your Care is on the delivery of safe and sustainable services for all the people of Northern Ireland. It would be wrong to say that cost-effectiveness is not a big issue because it is, of course, a key aspect, but the key focus is on safe and sustainable services. When the population plans are developed, different things will affect different areas. However, there will be consultation on any significant changes. Specific criteria are being developed, and population plans will be assessed against those criteria. However, the key and overriding aspect is about safe and sustainable services for all areas.

Ms Gildernew: That does not necessarily fill me with confidence because when the maternity unit at the South Tyrone hospital was closed, it was done on the basis that it was not safe. However, the alternative for years was less safe. So, "safe" and "sustainable" are not words that excite me after a number of years as an elected rep. I will leave that there.

I am disappointed that a bid was not put in for child and adolescent mental health services (CAMHS), because the Committee has talked about that on a number of occasions and the Department recognises that that area is underfunded. The shortfall there is year-on-year, yet no bid was made to try to improve services. Can you comment on that?

My last point is about the nurses' contract. You talked about staff savings, and the Chair asked about redundancies. Is there any thinking on renegotiating the nurses' contract?

Ms Thompson: In the context of the bid for CAMHS, you need to remember that, as a Department, we are not meant to lodge bids except in major and unforeseen circumstances. Therefore, the bids we have put in are to deal with significant issues, hence the scale of what we are talking about. As a Department, in the original budgets, we were allowed to retain our reduced requirements and have flexibility, which does not apply for any other Department. It is about prioritisation and ensuring that what we are putting on the table is major and unforeseen, and that is, effectively, where the bids have come from.

I am not aware of anything with the nurses' contract.

Ms Daly: I am not aware of any intention to renegotiate the nurses' contract. Any workforce savings through the voluntary retirement/voluntary early release (VR/VER) investment will be reinvested directly back into the health service. I do not know if that was the point you were making, Michelle.

The Chairperson: You can check the situation with the nurses' contract and come back to us.

Ms Daly: We will do that.

Mr Gardiner: I want you to elaborate on the section entitled "Social Care Reform", which refers to:

"Savings in management/administration of Older People Homes to reflect lower occupancy levels."

I do not like the phrase "older people". I have reminded and reminded the Department and it still cannot refer to them as senior citizens, which is what they are. You will all be in that category yourselves some day if you live that length of time. Now, can we get something on that from you?

Ms Thompson: Yes, absolutely. Management and administration are, obviously, a focus and the Minister is keen to ensure that we are reducing those costs as far as possible and ensuring that the more you can keep people at home, and it is back to the conversation we had around re-ablement and trying to treat people back at their homes, that can have an impact on the service provision that you require through residential care. Like all services, we then need to re-evaluate what administration costs need to be there to do that in as cost-effective a way as possible. That is where those savings are coming from. It is certainly something that all trusts are encouraged to focus on.

Mr Gardiner: Are you confident yourself that senior citizens will be looked after properly in their own homes rather than go into day care or full-time care?

Ms Thompson: That is the intention of all the services that the trusts have to provide, ensuring that people do get adequate, safe, sustainable services. The model suggested and proposed within TYC is that those people are supported as far as possible within their own homes, where that is appropriate.

Mr Gardiner: What mechanism do you have to check that the person is getting the attention they deserve and are entitled to?

Ms Thompson: The checks and balances are all within the trusts, if you like, to ensure that the care protocols for each person who is within their care are appropriately assessed and there is an assessment that goes on against each person and confirms the needs that they have. From there, the services are then provided.

Ms Daly: That is an area where also the integrated care partnerships, which will be developed under Transforming Your Care, will have a key role in coming together with all the key players — clinicians from trusts, GPs, social workers — in determining the needs for the local population. That should all take account of what is right for that person. Again, I know I go back to some of these words in 'Transforming Your Care' about the right service in the right place by the right person but that is absolutely a key focus of how services are intended to be delivered. The integrated care partnerships will be a fundamental aspect of that.

Mr Gardiner: How soon do you intend to put that into operation?

Ms Daly: The integrated care partnerships, under the commissioning plan direction, are targeted to be established in the current year. That is a target the Minister has set.

Mr Gardiner: This current year?

Ms Daly: Yes, 2012-13.

Mr Gardiner: Watch this space. Thank you.

The Chairperson: No other members are indicating that they want to speak, but I have a number of questions that I could have asked had other members not wanted to come in. Go ahead, Gordon. I did not even break eye contact there.

Mr Dunne: Thanks, Chair. You are very flexible and accommodating. You mentioned staff productivity and the reliance on agency staff. We are very much aware that there is a high reliance on agency staff. How will you manage that and how will we see that being implemented?

Ms Thompson: Again, it goes back to the issues around how you plan your staffing and rotas and ensuring those are properly planned for. Managing sickness: ensuring that the more you can reduce sickness can also reduce your agency staff. Using and maximising bank staff — those are their own nurses employed within the trust on a bank basis rather than on an agency basis. So, there is a range of things that help you to effectively look at where and how you are employing agency staff and whether you need to continue to do so. It does require proactive management. It is not something that happens easily but if, for example, sickness levels are reduced, that can certainly help to reduce agency staff.

Mr Dunne: Do you feel that, as a result, staff will feel less of a burden and overload than they do now? Do you think it will increase productivity and help staff to feel more valued than they do at the moment?

Ms Thompson: Certainly in terms of the things that we need to do to improve productivity, the likes of sickness absence is one part of that in keeping people at work and well at work and able to do their jobs and feeling that they are valued. So, that is all part of the mix and ensuring that, with proper planning, there are sufficient and appropriate numbers of staff on the wards and providing those services on an ongoing basis. But there is no doubt that they are under pressure.

Mr Dunne: They are? You admit that and recognise it?

Obviously, we are all keen to see Compton implemented. Is there funding in the budget this year to progress that successfully?

Ms Thompson: The £18 million for which we are bidding is not factored into our budget at this stage. The bid has been logged in June monitoring to allow that to happen.

The Chairperson: I want to go back over some of the points in the briefing paper under the heading of "Miscellaneous Productivity", where it mentions a "Variety of estates schemes", including energy and standardising car parking charges. There is an issue about the difference in the amounts charged in some car parks. I assume that you are going down rather than up.

Dr Bernie Stuart (Department of Health, Social Services and Public Safety): The new policy for car parking charges is about to be issued. It has been out for public consultation, and we were here a couple of months ago about that. It is a permissive policy which allows car parking charges. The trusts are all required to consult locally on each individual site, and that takes account of the charges in the area and the demand for the spaces. It is a mixture of traffic management —

The Chairperson: It says here, "standardising car park charges".

Dr Stuart: Yes, it is the first step towards standardising. The policy does not go as far as setting the same charge for each car park. There are a number of reasons why that cannot take place, such as planning constraints and the differences between the charges for parking on the road and in the sites. The City Hospital site, for example, has planning constraints on it. It is a matter of making a more standard charge for staff across the trusts where possible, and aiming to make it more consistent.

However, local circumstances always have to be taken into account in order to be able to manage the traffic. If you have a lower charge in the hospital and a higher charge on the road, clearly you affect the traffic flow. At this point, the policy does not require the same charge across Northern Ireland.

The Chairperson: OK. There are a number of points under "Dental". Are we not still out for consultation on dental services? One of the key points that was raised with the Committee was the changing of the scheme. There was also discussion about the criteria for orthodontic treatment. How can you put that down when it is still out for consultation?

Ms Thompson: These are all developed proposals. The ones for managing pressures are certainly proposals and are out for consultation, as you say. If those proposals have to be changed, it will not be the first time that we have had to adapt and change from that sort of initiative, or delay things. We will keep that under review, and as I come back through to the Committee on an ongoing basis, we can continue to keep you up to date with that. We have to make plans and proposals at the start of the year, and then we keep an eye on them as they change. Consultation is one reason why, potentially, things need to change.

The Chairperson: OK. Under Compton/TYC, you say that there is a possibility that £70 million will be required over the next three years to deliver the changes to the system. Kieran mentioned that earlier, and I congratulated him for getting the point in: how much of that £70 million will be spent on consultants?

Ms Thompson: We are not aware, at this point, how much of the £70 million would be spent on consultants —

The Chairperson: The Minister made a statement a number of weeks ago that millions will have to be spent to save millions in the future.

Ms Thompson: Yes, but you are asking for a precise number, and I am saying that we do not know that at this stage.

The Chairperson: You must know a ballpark figure, because you know that £70 million is needed to implement it.

Ms Thompson: At the moment, the work on the next phase of consultancy — the conversation with the Committee was about the planning and design phase — will be about implementation. That is all

still to be worked through in a business case and is still subject to approvals. I cannot give you a ballpark figure at this stage.

The Chairperson: OK. Will you give me a breakdown of the £70 million that you are putting in this briefing paper?

Ms Thompson: We can give you it across the years, but in terms of identifying an element to do with consultancy, apart from anything else, it would be commercial-in-confidence to do so and would not be helpful to have numbers out in the public domain.

The Chairperson: There is a figure there that says that it highlighted £70 million, and then you talk about the integrated care partnership, service charges, voluntary redundancy and implementation. There has to be a breakdown for you to have come up with that figure.

Ms Thompson: The 2012-13 analysis is behind the £18 million. In respect of the different elements of that, they interplay against each other, which is critical. Therefore, what we are looking at is £18 million in 2012-13 to implement TYC. A lot of that will become firmer when we have the population plans, as Catherine has already described. That will help us to be clearer about what will go where.

The Chairperson: OK. If I were sitting here as the Finance Minister and you came to me with a bid for £70 million, could you give me the breakdown for the £18 million for this year? If you are looking to the future, and the £70 million is the figure, you must have something, because I am sure that Sammy Wilson will not just say OK.

Ms Daly: You are absolutely right. Julie is right. We do not have the full breakdown in respect of the £70 million across the period. The bid today is the £18 million under four different headings: VR/VER; implementation; service changes; and integrated care partnerships. There are a number of different elements in each of those, and Julie talked about interplay. Those different elements will all come together. It is quite difficult to separate out the different elements. You are absolutely right. We could not go to DFP and say that we need £18 million but we do not know what the breakdown is. To a certain extent, we have to estimate what it is, and, sometimes, that is not helpful. We would not speculate, but, sometimes, it is not helpful to estimate.

The Chairperson: OK. You might not have it now, but give us the breakdown for the £18 million.

Ms Daly: OK, if you bear with me. In terms of some of the things that Julie said, for example, on implementation, an element of that will be consultancy costs. We can talk about reasons why that is the case. If we had that figure firm now, it would not be helpful to disclose it because it could prejudice the competitive tendering process for those consultants, and it would not be helpful for that to be out. However, in respect of those four areas, if we look at VR/VER, what will happen to the workforce will depend on the population plans. However, we would look and say that, over the four-year period, we would expect that 1% of the workforce would be affected by that. Therefore, out of 70,000 people, you are talking about 700 people over the whole period.

If we look at what might happen in the current year, if 100 people are affected by voluntary redundancy or early retirement, it will be in the region of £5 million. That gets complicated, because, under the budgeting rules, we can accrue for voluntary redundancies and early retirements in future years. Therefore, there is scope to be more efficient in using the budget and secure a greater level of expenditure for forward years.

I am not trying to complicate this process, but if you look at that and say that that is roughly ballpark, £5 million for VER, we would expect that there would probably be an equal split across those three areas. When you go into the implementation costs, if we took the £5 million out of the £18 million, which leaves £13 million, you would be talking about roughly £4 million across each of the areas. That £4 million on implementation would not be for consultancy costs, but it would be an element of that.

Julie may want to say more about this issue, but we have a target to keep consultancy costs as low as possible. Our objective is to use the minimum extent of external consultancy, because the focus will be on building capacity within the existing service. I know that that is not giving you a precise breakdown.

The Chairperson: It is not. We are here to scrutinise, so it is important that we get as much information as possible. Let me ask you this question: you talk about additional in-year funding of £22 million to address the backlog in the waiting list, and you mentioned that earlier. Can we have a breakdown of that?

Ms Daly: Yes, I can give you a breakdown of that across those five specialities. For orthopaedics, the backlog waiting list for assessments is 4,500, and for treatments it is 2,600. Those will be dealt with either as day cases, inpatients or outpatients. To clear the backlog for orthopaedics with that combination will cost £15 million. For ophthalmology, there is a backlog for assessments of 5,000, and it will cost £2 million to clear that. It will cost £3·5 million to clear a total backlog of 6,200 for general surgery, £1 million for dermatology and £0·5 million for gynaecology. There is a different combination of costs for each of those. In some cases, it is day case treatment, in some cases it is inpatient and in others it is outpatient, and the cost varies significantly between those cases. However, we can certainly provide details of those average costs.

The Chairperson: Finally, you will be glad to know, you said that the current capital investment is overcommitted by £74·9 million. Some members asked questions relating to that. What projects are overcommitted?

Dr Stuart: It is not that any specific projects are overcommitted. We are given an allocation across the years. Normally, we over-profile by a certain percentage to allow for slippage between the enabling works and the main contract starting, or business case approval. For this year, we are overcommitted by roughly £5 million, which we are fairly comfortable with at this point in the year, given the fact that we are only coming into June. There will be a £30 million to £38 million overcommitment for the next two years, and we are less comfortable with that. It is really when you add in all the large projects. We have also profiled in the ICT requirement, the fleet for the fire and ambulance and an estimate of need for general capital and equipment. It is really looking at our need in total and saying that, at this stage, if we did everything that is in the programme, we would be overcommitted. Therefore, we are looking at stopping points. For example, we could put in a pause between enabling works and main schemes. What would we have to delay if we did not get additional funding? It is not that a particular scheme is overcommitted: it is just the timing of when they can all start. As we move closer to the start of next year, we will want to have that down to a much lower level of overcommitment.

The Chairperson: Finally, Julie, you mentioned the PEDU report earlier. We have still not got a copy of it.

Ms Thompson: It is with the Office of the First Minister and deputy First Minister. We will need to ensure that it is releasable to the Committee. However, I am happy to take that back and pursue it.

The Chairperson: On behalf of the Committee, thank you very much for your presentation and your answers. See you soon.