Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Planned Expenditure 2012-13 and October Monitoring Round: DHSSPS Briefing

26 September 2012

NORTHERN IRELAND ASSEMBLY

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

Witnesses:

Dr Bernie Stuart	Department of Health, Social Services and Public Safety
Ms Julie Thompson	Department of Health, Social Services and Public Safety
Mr Peter Toogood	Department of Health, Social Services and Public Safety

The Chairperson: Bernie, Peter and Julie, you are welcome. Thank you very much for the information that you sent to the Committee. You will have heard most, if not all, of Colin Pidgeon's presentation and some of the questions from members, so I will hand straight over to you to make a presentation, and then we will open up the meeting for questions.

Ms Julie Thompson (Department of Health, Social Services and Public Safety): Thank you for the opportunity to provide evidence to the Committee. We have provided information on a range of matters, including the requested planned expenditure for 2012-13. More recently, we supplied information on our participation in the October monitoring round, so I will go through both briefing papers.

I will start with planned expenditure for 2012-13. We have discussed at previous Committee meetings the range of financial information, the purposes for which it can be used and how it can be compared. Indeed, that was discussed by the Committee earlier today. It is a complex area, and, in that context, it may be helpful to set out some of the bases of how we prepare the analysis.

For 2012-13, the programme of care (POC) analysis in our briefing paper reflects the totality of the Health and Social Care Board (HSCB) and Public Health Agency (PHA) budget allocation from the Department. It includes recurrent and non-recurrent sources of funding. That represents a change from the analysis that we provided last year, which contained only the recurrent funding available at the start of the year. Last year, the Committee had raised with us the issue of trying to move that position on, and having heard the helpful conversation about that subject earlier, I hope that this

represents one element of what the Committee requested then. Comparisons with previous years are, therefore, more difficult because we have changed the basis for 2012-13 from what it was previously.

The total planned expenditure for the Department of Health, Social Services and Public Safety amounts to £4·5 billion for 2012-13. Of that, 89% is allocated to the board and the PHA for the purposes of purchasing hospital services, community services and personal social services (PSS) at £3·1 billion; and for delivering family health services at £0·8 billion. Members will note that the acute services programme of care amounts to £1·4 billion, or 44% of the total planned spend. That POC includes accident and emergency, together with surgical and medical procedures. As such, it represents a significant proportion of the key services provided by Health and Social Care.

Elderly care is the second largest area of expenditure, accounting for 21%, or £634 million, of total expenditure. That POC captures planned spend across the hospital, community and PSS sectors and includes spend on specialist nursing support, allied health professionals and domiciliary and nursing home care.

Planned expenditure on family health services is some £832 million, approximately half of which is pharmaceutical spend.

I can move on to October monitoring, or do you want me to stop there?

The Chairperson: You probably missed me saying earlier that we would have two discussions so that we can have a clear run at each issue. Is that OK with you?

Ms Thompson: That is absolutely fine.

The Chairperson: You provided figures representing the expenditure and opening budget at the start of the financial year. Why is the Committee getting that information only now, rather than on 1 April?

Ms Thompson: The information contained in the commissioning plan is high level. We then worked that through, as requested by the Committee. It could, potentially, have been provided slightly earlier, but we were following the same process as last year and did that at the Committee's request. Do you want me to produce the analysis earlier next year?

The Chairperson: I would like it in April next year.

Ms Thompson: That should be possible.

The Chairperson: I will allow that to go. We are entitled to get information from the Department.

Ms Thompson: Absolutely. The only reason I hesitate is that we need to work down the numbers into each programme of care, but I accept your point.

The Chairperson: If we are talking about April to April, you should have that information ready. So if we can get that as early as possible, in and around April or May, it allows us to think of the financial rather than the calendar year.

The Committee is due to hear evidence from the Minister in the next week or two on Transforming Your Care (TYC). Its vision is of shifting services from the acute sector into the community. Do you have any evidence of that happening? When do you think that we will see evidence of the shift of allocations into the nine programmes of care? That point was touched on in the earlier research briefing.

Ms Thompson: You are quite right that it is early days for Transforming Your Care, which refers to shifting approximately £83 million from hospital services into the community setting. We are working with the HSCB to understand that and to see how that would flow through, particularly into 2013-14 and 2014-15. So it is too early to see a shift in these figures, but we expect it to come through in later years.

The Chairperson: So will we see that starting to fit in at the out-turn of 2011-12?

Ms Thompson: The year 2011-12 is pre-TYC.

The Chairperson: When will the out-turn for 2011-12 be available?

Ms Thompson: At the level at which you have it, the out-turn for 2011-12 should be available now. The more detailed information that Colin worked through, which is analysed by POC, is not available yet but should become available in the next month or two. We can provide you with the high-level information for 2011-12 now, but we cannot yet do the more detailed one that was referred to earlier.

The Chairperson: We are nearly at the end of the financial year. OK, I will come back to that. In fairness, Colin said that you were very supportive in providing information this time round, as opposed to the last time, and that should be commended. However, I just do not know why it has taken so long for us to get some of these figures. Our projecting and planning, especially when it comes to Transforming Your Care, is not just for the next month or six months; we are talking about future years, so we need to have all the information. The evidence has to be there to prove the need for additional resources, requiring money from monitoring rounds, so that the Committee can support that. Unless we have all that information, you will just get blank stares and questions about why we do not have the information to support what you are trying to do within a policy directive.

Ms Thompson: As I said, the 2013-14 position is dependent on the commissioning plan provided. That is all worked through earlier, and we will be able to work through the numbers in the way that you have described before the new financial year. I am happy to take that point back to the Department.

As Colin said, the details of the 2011-12 financial position have to go through the audit process, and so on. We can do a high-level analysis but not the detailed analysis that splits the financial information into various categories. That takes time, and the 2011-12 analysis is due out in the next month or two. I appreciate that that may cause concern to the Committee, but you are waiting for audited information, which then has to be broken down by organisation across the system.

The Chairperson: The Department submitted an invest-to-save bid of £19 million. Is there any word on whether that was successful?

Ms Thompson: My understanding is that that will be announced by the Minister of Finance and Personnel as part of the October monitoring round.

The Chairperson: OK, I will leave it at that.

Mr Gardiner: The officials were in the Public Gallery, so they will know my question. Do you have an answer for me, Julie?

Ms Thompson: Is this the question about paediatric services?

Mr Gardiner: Yes, my question is on two programmes of care: maternity and childcare, and family and childcare. The combined planned expenditure is £323 million, but why are they separate? Paediatric congenital cardiac services are delivered in Belfast. Does this double listing create any financial room for any reconsideration of the future of paediatric congenital cardiac surgery and services in Belfast?

Ms Thompson: I think that paediatric congenital cardiac services might be in the acute services envelope, because it is very much an acute service. It is not in either of the two POCs that you mentioned, which are more to do with community-centred services, such as child health. I am happy to come back to the Committee to confirm exactly where the paediatric and other services are.

Mr Gardiner: There could be savings there. I do not know, but you have to look at that again.

Ms Thompson: Obviously, paediatric congenital cardiac services are the subject of a review, which was debated in the Assembly yesterday.

The Chairperson: In fairness to the Minister, he said that paediatric cardiac services were not a finance issue and that it was more about the level of services, and so on. It is not as if we are saying that the Department needs to find money for them. The Minister has confirmed over the past weeks, and again yesterday, that it is not a money issue. I am starting to speak very highly of the Minister.

Mr Gardiner: Are you likely to be the next Minister? *[Laughter.]*

The Chairperson: Not a chance. *[Laughter.]* There needs to be a stewards' inquiry into that, but credit where credit is due: he said that this was not a funding issue.

Mr McCarthy: You probably heard me ask Colin about figures for ill-health prevention. We understand that, last year, unspent money had to be handed back. I think that it was £19 million.

Mr Brady: That was the figure quoted, if I remember rightly.

Mr McCarthy: That was £19 million for prevention and health promotion that had not been spent.

Ms Thompson: If I can recall from last year's discussions, there was difficulty comparing planned and actual expenditure. That caused significant confusion at the previous meeting. It was not a question of money not being spent; it was a comparison issue.

Mr McCarthy: The other issue relates to the data provided year to year. Again, I asked this question of Colin: can we be assured that the Department will provide us with data that will accurately show comparisons so that we will be able to see whether expenditure in the different POCs is in line with data expected from the roll-out of TYC?

Ms Thompson: That is similar to the Chair's question on when TYC will be reflected in the programmes of care. You would expect to see that shift happening in the programmes of care in the 2013-14 plans to a certain extent, and we need to work through that. We are doing work, not just on 2013-14 but, as far as we possibly can, on 2014-15. So the answer to your question is that we expect to see that shift starting to come through in 2013-14.

Mr McCarthy: That is fine, thank you.

Mr McDevitt: I do not want to rehearse the issue of planned versus actual expenditure, but the divergences are significant. Take the programme of care for primary health and adult community as a case in point: the table in your briefing paper shows planned expenditure for 2009-2010 of £103 million, with actual expenditure of £138 million; and planned expenditure for 2010-11was £100 million, with actual expenditure of £154 million. We do not know what the actual expenditure in 2011-12 was, but we know that planned expenditure was £100 million. According to the figures that you provided, if I am reading them correctly, planned expenditure for 2012-13 is £102 million. How much confidence can we have in those planned expenditure figures?

Ms Thompson: I guess that it comes back to the comparability of those particular data sets. As Colin explained, one set is on trusts and how they provide services; the other comes from the board and the PHA. If it is helpful to the Committee, I can certainly look into that and provide a more detailed explanation of the one that you described.

Mr McDevitt: There is a basic accountability issue in that we are asked to approve planned expenditure. If I were to surmise the trend, I would say that, invariably, in the past four years, actual expenditure is approximately 50% higher than what was approved as planned. We are not talking about loose change at the bottom of the bucket; we are talking about very significant disparities. I would have thought that we need the figures. How do you explain the system being able to churn out two such different data sets?

Ms Thompson: I would need to look into the specifics of the example that you described. The discussion this time last year was about the fact that it was more appropriate to compare planned expenditure over a period and then actual expenditure over a period. However, I fully appreciate your point that, if those two bases are not on a similar comparable issue, you cannot compare them. It is probably better that I look at the detail and come back to the Committee on that.

Mr McDevitt: I have one further probe on this subject, and I wonder whether this might be the answer to my question. The planned expenditure on the health promotion POC for the years 2009-2010, 2010-11 and 2011-12 was £94 million, £93 million and £104 million respectively. However, actual expenditure in 2009-2010 was £46 million, which is a long way short, and in 2010-11, it was £47

million, which is basically half of what was planned. We do not yet know what the actual expenditure was last year or this year. Then, we have the planned expenditure for 2012-13 of £109 million, which is a huge jump. The point is that actual expenditure is only ever half of what was planned. I do not want to ask the obvious question, but how the hell can you know what is going on when presented with such disparate figures?

Ms Thompson: It comes down to the bases on which the figures are prepared. Last year, we went into the health promotion figure in great detail, and I guess that this is at the heart of Mr McCarthy's question. The actual expenditure figure that you quoted is the spend directly incurred by trusts on health promotion, whereas the planned expenditure figure is a more composite number reflecting PHA spend that goes directly into the voluntary and community sector and that is issued through other means. That is one figure for which I can explain the difference, because we went through all of that this time last year.

For the primary health and adult community figure, I would need to go back to understand in more detail what is going on. The bases are not the same: one is derived from the trusts; the other from the board and the PHA. The discussions of last year were about trying to understand planned expenditure as a trend and actual expenditure as a trend, rather than comparing like with like.

Mr McDevitt: Surely then, the figure for your planned expenditure should be always larger than that for actual expenditure, because it includes all these other things. However, if I look at the bottom line, I see that the figure for actual expenditure is larger than that for planned expenditure. In other words, the line that is more restrictive comes out with a higher figure than the one that you tell me includes all these other elements that are not actual expenditure. How do you explain that?

Mr Peter Toogood (Department of Health, Social Services and Public Safety): There is a further dynamic at play.

Mr McDevitt: This is not helping. I am deadly serious. From the point of view of public confidence in the administration of health and social services, this really does not help. It creates the impression that nobody knows.

Mr Toogood: There is an explanation, which comes on the back of what Julie was saying about the comparability of the data. We have not seen Colin's paper, so I do not know its content in detail, but, essentially, the planned data are done at the start of the year whereas the actual data are entered in retrospect. The actual expenditure then reflects either budgetary alignments from the Department, as Colin referred to, or in-year —

The Chairperson: Did you say that you have not seen the papers that we are working from?

Ms Thompson: We have not seen Colin's paper.

The Chairperson: Did Colin not get the information from you?

Mr Toogood: Yes, but we have not seen the way in which it is set out.

The Chairperson: Colin's information came from the Department.

Mr Toogood: Absolutely, I am not questioning that.

We get additional in-year monitoring moneys that would not have been anticipated at the start of the financial year in the planned expenditure. That comes through in the actual figures as well. It is a complex area with a number of dynamics at work.

Mr McDevitt: It is a confused area, because you are not able to track it, and you are the people in the system whose job that is. You are expressing the fact that the two sets of figures are, to use a very simple analogy, apples and oranges. That is not just complexity; it is confusion, and it makes it really difficult for us to have any confidence in what we are scrutinising. I am no expert, but I would like to think that I can read a basic balance sheet. This makes it very difficult for me to follow anything.

Ms Thompson: Part of the issue is how we monitor generally. Monitoring is about holding organisations to account and making sure that they break even against the budgets that they are given. The Committee will be very aware of the strong financial performance. Delivery against ministerial commitments is about delivery against the commissioning plan direction and the performance management of targets against the Programme for Government commitments. So it is not the case that finance stands alone. When it comes to whether targets are being met, or otherwise, accountability is not only for financial performance but for service performance. This is one element of a jigsaw, and it is not to be viewed in isolation. We hold organisations to account monthly. Their performances are monitored extremely closely, and break-evens and getting to an overall break-even position are also closely scrutinised. So there is a huge focus on ensuring that organisations deliver within plan.

The Chairperson: Conall has made a very important point. We are being asked to plan, think outside the box and look at how Transforming Your Care will impact further down the road. I have a concern based on what Conall said, and I assume that he has the same concern. It seems that the decisions are made through the Programme for Government, collectively in the Executive, and then filter down to Departments. The Department that we have responsibility for scrutinising also has plans for the following year. You calculate the projected cost, but it does not seem to me, although I could be wrong, that the trust is on the same bus as you, never mind the same road. Then, come the end of the year, whatever the plans of the Department, the board and the PHA, the trust seems still to be doing what it is doing. That, in itself, is down to some of the expenditure in the programmes of care. I am conscious of the fact that you have only just received a copy of Colin's paper. However, that is based on the information that he got from you. When we talk about planned versus actual expenditure, how can we be sufficiently confident that the Department, which drives the bus, knows the destination and can take us to it given that the trusts seem to be the passengers dictating where the driver goes?

Ms Thompson: Obviously, the ministerial drive comes from the Department and the Minister through the commissioning plan process, which involves the setting of the commissioning plan direction. The commissioning plan then sets out the detail of what has to be delivered, and that is performance-managed through the system. The organisations are then given their budgets and are held to account against those and against the performance targets that they have to achieve in the commissioning plan direction. So it is all —

The Chairperson: Julie, I appreciate that, and I do not want to give you a hard time, but we got the commissioning plan only two weeks ago. You might have the vision, but we are a number of months into the financial year. Given that we get some of the information near the end of the financial year, where is the joined-up approach from the Department, board, Minister, officials, trusts, the PHA, commissioning groups, and so on? There does not seem to be a joined-up approach to the vision.

Ms Thompson: I appreciate that. Steps are already in train to plan for 2013-14 and to ensure that those documents come out earlier.

The Chairperson: You can understand our position.

Ms Thompson: I certainly can understand your position.

The Chairperson: There may be elements that you believe need to be changed, and we are here to support you as much as give you a hard time.

Mr Dunne: I thank the panel for coming along this afternoon. We sat here this time last year and were hit with plans to make massive savings. Some one hundred-odd million pounds had to be found. Is there a risk of that happening again this year, or have those issues been resolved? Have we moved on?

Ms Thompson: The position has moved on. We have a range of savings plans for 2012-13, and I went through those with the Committee at the end of May. Are we in balance yet? Not quite. We still have an element of deficit and a funding gap that we have to find a way to manage. We have not quite resolved that yet. However, our position is such that we believe that that is manageable between now and the end of the year.

Mr Dunne: So those cuts were implemented during the past year. I think that cuts of £100 million, or maybe even £140 million, were talked about at one time.

Ms Thompson: The 2011-12 budget balanced. In 2012-13, we have £185 million worth of savings to identify and find. What I am saying is that a large portion of those are in train and are now working through. We have not quite squared the circle at the bottom. However, we are confident that, between now and the end of the year, we can find a means of reaching a balanced position. We are not quite there yet, and we have to achieve £185 million of savings in 2012-13. That detail was contained in the Committee's briefing paper for the June meeting after it had been discussed at the end of May.

Mr Dunne: How are we going to do that? The big issue with any organisation, especially one as large as the health service, is the cost of salaries and wages. It jumps out at you from the briefing papers — roughly 50% of the budget is spent on salaries and wages. It sounds like a huge amount of money.

As elected representatives we are more and more aware of the need for more staff at ward level in the health service. How can we address that? It is extremely difficult to do it. We are told that it is not about money. There is obviously an increase in the budget for this year, and we are up to almost £4·5 billion, which is a huge amount of money. How can the Department get more efficiencies and get the trusts to be more effective and focused on managing the resources that they have?

Ms Thompson: We have a wide range of efficiencies in play across all bodies and sectors. For example, in the acute sector you might be looking at reducing the length of stay and doing more procedures through day surgery. You might be looking at managing sickness costs, absence, skill mix, procurement, management costs or discretionary expenditure. There is a whole gamut of savings, and the briefing paper for our May visit set that out in more detail for the Committee.

Those plans are being worked through at this stage. We are not quite in a balanced position, but we are hopeful that we will reach it. There is a wide spectrum of efficiencies across the sector.

You are quite right that a large portion of the budget is spent on staffing, and the numbers are significant in that regard, with over £2 billion being spent on staffing.

Mr Dunne: We had a briefing on osteoporosis this week from the National Osteoporosis Society. One thing that came out of that briefing was the disparity in the treatment of osteoporosis across the various trusts. That is just one example. How accountable are the trusts to the Department for the way in which they spend their money and the levels of service that they provide in their areas?

Ms Thompson: They are accountable in several ways. They are held to account for the delivery of performance targets, a balanced budget and efficiency savings within plans and for the quality of services that they provide through the implementation of a wide range of quality indicators. When we address accountability with the trusts, it covers a whole spectrum all the way from the governance of the organisation through to quality, performance and finance. That is the gamut of accountability to which the Committee would expect us to hold every individual organisation on an ongoing basis.

Mr Dunne: Are their spending priorities delegated to them, or do they have to work from the departmental plan?

Ms Thompson: They have to produce a balanced budget and identify how they are going to achieve targets, and they have to produce a savings plan. Every aspect, effectively, of their service has to be worked through in that way. The Department does not monitor that in complete detail, nor does it know where money is being spent from day to day, but we monitor the overall financial position and how the savings plans are being achieved. You set out a plan, and you work through from there.

Mr Dunne: You probably know what we are getting at, Chairperson. You highlighted the disparity across the various trusts. We would all strive for equality; indeed, we have had a paper on health inequalities. There are inequalities because some areas have services while others do not. We need to do more to ensure that services are provided equally across the trusts, and financial accountability is surely a part of that.

Ms Thompson: As I said, financial accountability is monitored with those organisations. On the health inequalities point, when we are giving out money in budgets to local areas, we take into account the

relative needs of those populations. A capitation formula works through and takes account of health inequalities when the budgets are being divided up across Northern Ireland.

The Deputy Chairperson: In the previous dispensation, there was a special arrangement with the Department that you did not have to apply to the Department of Finance and Personnel (DFP) for permission to move money around budgets. In return, you got the first call on £20 million in the monitoring round with no further money. Is that flexibility still in the Department?

Ms Thompson: Yes. We were going to cover October monitoring separately. Do you want to go into that conversation now?

The Deputy Chairperson: Yes.

Ms Thompson: Yes, we still have the flexibility to move money around the Department, but we do not have the additional guaranteed first call on the £20 million.

The Deputy Chairperson: You do not get the first call, but, with hindsight, which was more advantageous, first call on the £20 million or the ability to make your three or four bids a year? Which has worked out to be more to the betterment of the Department?

Ms Thompson: They are both of benefit. Anything that brings money back into the Department is of benefit. I guess that you have to look at whether we got more than £20 million back. I would need to analyse that, but we still have the ability to retain moneys in the Department to be used as appropriate without having to be returned to the Executive pot.

The Deputy Chairperson: In previous years, you had a pay freeze for everyone earning £21,000 and above. That has stopped. What are the implications of that for your budget?

Ms Thompson: We factor that in, as we do with all cost increases. Apart from pay, you can get inflation on a wide number of budgets. It will be factored through into 2012-13, and we will then try to make a forecast for 2013-14 and 2014-15. I do not have the numbers right here, but part of our process is to look right across the budget and establish where are costs are going to increase no matter what we do. We bring that in and then look at savings, effectively, to manage those increased cost pressures.

The Deputy Chairperson: You have built in £25·6 million for a series of headings, one of which is redundancies. I presume that those are still voluntary.

Ms Thompson: Yes, they are voluntary.

The Deputy Chairperson: So, do you believe that you can get £185 million of savings in this financial year, 2012-13, without having to invoke any compulsory redundancies?

Ms Thompson: That is our current plan and understanding.

The Deputy Chairperson: Despite the fact that some had said that 4,000 people would be thrown onto the dole, you have managed to achieve that saving, even in the second year, and no one will compulsorily be made redundant?

Ms Thompson: That is our current plan and understanding. Absolutely.

The Deputy Chairperson: Do you think that that will be the case the following year?

Ms Thompson: We need to work through the detail for 2013-14. Obviously, every effort will be made to avoid any compulsory redundancies, but we have not done the full detail on 2013-14 yet.

The Deputy Chairperson: What savings are you expected to find in 2013-14 on top of the £185 million this year?

Ms Thompson: It is of a similar order. Again, we have to do the detail around 2013-14 and work that through with all the organisations and establish that. It is always going to be a significant amount of money, and it will be of a similar order, although maybe not quite as high.

The Deputy Chairperson: Of course, these are cumulative savings?

Ms Thompson: Yes, they are on top of each other.

The Deputy Chairperson: You might say that having saved £200 million last year, it is no problem to save £185 million, but that £185 million would be on top of the £200 million that had been saved already.

Ms Thompson: The savings are always on top of each other, and that has been the case as we have gone through the previous comprehensive spending review (CSR) period and this CSR period. When the trusts find savings of 3% or 4%, those are always added on every year. That makes the task harder and harder and harder to deliver, and that is why you have to look right across the spectrum of all of the services to see what you can deliver. I guess that it also gets back to the issue that so much of our costs are incurred by staff.

The Deputy Chairperson: What assumptions have you built in for Transforming Your Care? Is anything built into this year's budget apart from the cost of that project, as it were? When do you envisage Transforming Your Care starting to have an impact on the overall figures?

Ms Thompson: As we discussed slightly earlier, you would expect to see a switch from acute services towards more community and primary-care-based services starting to come through in 2013-14. That is more of an issue for 2013-14 than 2012-13.

The Deputy Chairperson: What do you expect the financial outcome to be?

Ms Thompson: The 'Transforming Your Care' report sets out that it is assumed that £83 million approximately will transfer from acute into those other services by 2014-15, and we are still working through the detail of that, particularly with the regional board, to establish how quickly that happens and what it looks like. We expect it to start to come through in the numbers in 2013-14.

Ms Maeve McLaughlin: Thank you for that. I am becoming more confused when listening today, and it goes back to the conversations that have taken place. I listened carefully to your analysis of holding other organisations to account and planning budgets, yet I need to reinforce the point that we have been told that the Department does not have a baseline and that some aspects of the budget are being driven by trusts or through the PHA. I find it less than acceptable, in the context of our process of scrutiny and accountability, that we do not even have that clear overview. In fact, we are faced with clear disparities and differences between actual and planned spend, and I would have thought that there was a requirement on the Department to have that baseline information for all those services.

My second point is about expenditure, specifically in the paper from Colin. There has been a decrease, for want of another description, in some themed areas, such as acute services, elderly care, mental health, health promotion and disease prevention. How does the Department benchmark and prioritise those issues?

Ms Thompson: You are looking at a range of issues to determine where money goes. First, you have to take into account the inescapable costs that the Chair talked about, such as pay and non pay, and those issues have to be worked through across each service. Then, to meet targets, you need to look at what ministerial and departmental priorities should be invested in and where they fall. For example, if we put money into specialist drugs or waiting times, they would have to be then factored in by programme of care. A large portion of the budget is already spent in the individual areas. It is not the case that you lift the entire budget up every year and put it in an entirely different place; you have to move the new money in gradually and look at how you can take savings out. That goes back to the point raised earlier: when you look at that £185 million, how does that go across the individual services?

We take the baseline, add the extra money to each programme of care and take off any savings that can be achieved in the programme of care, and the net result is the new amount of money. That is not enough, because you then need to take into account the targets set through the commissioning plan

direction, where the organisations are held to account for delivery and the Programme for Government commitments. It is not just the financial envelope itself. We then look at the bottom line financial position, and the Committee, rightly, is concerned about the bottom line and whether we can live within our resources. That is monitored, as are individual savings plans. It is a very complex area, but we need to look at the pressures that exist across each programme of care and put money into those.

Ms Maeve McLaughlin: That is fine up to a point, and I have taken on board the process that is involved, which is not just about the financial package. That is my point. I look at issues in the report such as mental health, and there is clear evidence of increased levels of mental health issues in our communities — I will not open up the discussion about why that is — yet we are faced with a decrease in that expenditure. Therefore, I suppose the point that I am making is about ensuring that departmental priorities are reflective of the need and that the benchmarking process takes place to do that. It just does not add up, and I am sure that if you took it out to the wider community, it would not add up. There is a responsibility on all of us to say that. I am making the point that I accept that there are processes around that, but, even in areas such as elderly care, we are constantly being told that there is an ageing population, yet we have a decrease in that budget. Therefore, it is about ensuring that what we do in order to scrutinise your role is reflective of the needs of the wider community and getting a sense that the Department does that as well.

Ms Thompson: The needs issue is complex, and you will be aware of the constraints on the budget. We do not have all the money that we will ever need to meet all the needs. Therefore, we have to prioritise and look across the programmes of care and what absolutely has to happen and what extra resource can be put into individual areas. For example, it takes additional money for hospitals to resource the resettlement programme for mental health patients in long-stay hospitals. Savings could be made by reducing extra-contract referrals, which are referrals over to England. If we could do those here, that could bring the spend down. Therefore, it is a very complex analysis that results in the numbers that you get to look at. We are reflecting a whole range of cost pressures, but we are also asking every service what it can do better and what it can deliver more effectively. You are right to say that there is a hugely increasing demand in elderly care, for example, and so you try to manage that demand and make those services more efficient. That is where concepts such as the reablement model kick in. It is about trying to keep people in their own homes, with support, so that they do not end up in long-stay institutions unless they absolutely have to. Therefore, there are means of managing those budgets. That is what Transforming Your Care picks up and considers the best and most appropriate ways of doing, and that will have an impact on the budget and the bottom lines. However, we cannot sit still and let the demand completely increase.

Mr Brady: To follow on from Maeve's point, my own experience from working in the advice sector is that mental health problems are on the increase. The figures reflect that, not only are the trusts not being proactive, they are not even being reactive, in a sense, because the figures are going down.

It is the same with elderly care. A lot of older people who go into hospital are suffering from malnutrition for various reasons, and it costs more money to bring them up to a particular state of health or to be treated. Therefore, it is about being proactive. We are going to talk about health inequalities across the trust areas. Some of those figures reflect that the trusts are not being proactive in many areas. We have talked a lot about Transforming Your Care targeting specific groups, particularly in respect of social care. Obviously, we are looking forward to that, but that has yet to be seen. I just want to make that point, and I think that what Maeve said illustrates that. You need to be proactive. Prevention is much better than having to treat at the end. That is a very simplistic thing.

Ms Thompson: Learning from best practice — doing things the best possible way and ensuring that, where things are being done well, that is shared with other organisations across the piece — is absolutely the right thing to do.

Mr McCallister: I apologise for missing the start of your presentation. I apologise if you have already given the figure, but how far are we from getting that £185 million? We got a running commentary on it last year.

Ms Thompson: We are between £15 million and £30 million still shy at the bottom line of the Department.

The Deputy Chairperson: It is always that figure every year, but you always make it in the end.

Ms Thompson: You are right. It is not unexpected to have a deficit of that level at this time of the year, and we will continue to work with that through the year to try to get to a balanced position by the end of the year. Therefore, it is not unusual to have that scale of a problem at this point. We will keep that under review; we will keep monitoring and keep the Committee regularly updated.

Mr McCallister: I will pick up on a couple of points that the Chair made. How many people have you taken off the staff in voluntary redundancies over the past year or two? If you do not have the figure with you, perhaps you would send it to the Committee. Is it a sizable number? Are we absolutely confident that we are not taking people out and driving up waiting lists or waiting times? One of the problems that most of us, as constituency representatives, face is that, sometimes, somebody goes off or leaves a job and the post is not refilled. That might be good for the accountants and suchlike, but it is not particularly good news if you are waiting for physiotherapy.

Ms Thompson: It is about taking out posts in appropriate areas where you can. With the likes of Transforming Your Care and the shift that we have been talking about between the acute side and the community side, you may find that, in the acute sector, you do not need the same level of resource and that voluntary redundancy could be one mechanism of helping you to manage your way through that. You will obviously be looking at retraining and redeployments as well. Staff turnover helps you as well. Redundancy is not alone when it comes to managing the position. It is one way in which you can help to make the shifts that Transforming Your Care envisages happening.

Mr McCallister: It would help if you could provide the Committee with some of the numbers.

Ms Thompson: We could certainly look at the numbers for 2011-12 and get those to you.

Mr McCallister: The original plan in Transforming Your Care is to move 5% — some £83 million — across from acute. Has that really started at all? Are we moving anywhere with that?

Ms Thompson: We have looked, at an initial level, at what that might take, but it has not yet translated into the delivery of the service on the ground. Obviously, TYC needs to go through the consultation process that is planned. You would not expect it to be seen in the numbers in 2012-13, but as we have been discussing, you would expect to see that making a difference in 2013-14 and even more so in 2014-15. That is where it will come through. We have done some analysis around what that might look like and the things that might help it to happen, but it is preliminary at this stage and has not affected the numbers on the ground.

Mr McCallister: By the time you finish this financial year, the TYC report will have been out for about 16 months. Although you would not have expected to see a lot of it in operation at this stage, I would have thought it reasonable to have seen something.

Finally, finally, as everyone usually says, when you look at trusts and efficiencies, how do you ensure that they are always pushing services and evaluating whether some of those services could be delivered by social enterprises, other charity sectors or the private sector? How do you ensure that they are pushing that, or do you not have any real control over how the trusts do that? Do you just set them the figure and it is fine as long as it happens? Can they push it more efficiently? Before I came here, I was at a Bryson Charitable Group conference. One of the issues was how it tenders or competes on a level playing field with the public sector. It very clearly made the point that, in some cases, the public sector perhaps can do it as well and better, but how do you make sure that you at least have that element in it? I assume that you just set the figure and let the trusts work to it.

Ms Thompson: No, it is not quite as simple as that. We certainly set the figure. You then look to see how they deliver; you look at a range of performance-type indicators. You also look at the best practice question that we talked about earlier to ensure that, if there is another means of doing something that is more efficient and provides a better service for patients and clients, those things are picked up and worked across the Province. That is predominantly worked through by the regional board with the trust to ensure that that learning effectively happens.

The challenge of living within budgets forces every organisation to look anywhere and everywhere that it can in order to try to balance its books because, as we have discussed, the numbers continue to accumulate year on year. To a certain extent, it is driven by the target, but it is also about picking up learning and ensuring that, if there is a better way of doing something, it is worked through. Procurement helps by providing value for money and working through procurement processes, and

business cases justify where you can put additional resources. All of those are supporting mechanisms to ensure that money is put in the appropriate places and that savings come out in the right way.

The Deputy Chairperson: I think this is around the sixth or seventh time that you have been before the Committee with this type of message. You always remind me of a young, female Houdini, handcuffed and chained in a glass tank full of water. We all wait with bated breath throughout the year — is she going to drown or not — and suddenly, at the last minute, you burst out and balance your budget. *[Laughter.]* I am slightly worried that some day that might not happen. The excitement is great, but we would like to have a wee bit more security.

A lot of what you are suggesting is based on assumptions. For instance, you are assuming that your invest-to-save bids will be successful. You are assuming, as John has pointed out, that a certain number of people will come forward to take voluntary redundancy, and I assume you have also built into your assumptions that you are going to get a certain amount in the monitoring rounds. One by one, those open all the padlocks, but I am just worried in case one of them does not deliver and you drown. Would it not be better to have a situation whereby, at the start of the financial year, you could sit down and say how you are going to find £185 million, and have it clear at the start of the year, rather than building up the excitement to see whether you can find £15 million here and £20 million there? Would it not be better to say, "Look, this is where it is coming from", and tells us in April rather than tell us —

Mr McCallister: You should never peak too soon. *[Laughter.]*

The Deputy Chairperson: It makes for great drama, but it is this same process each year: "We are confident that we are going to find this and that". A business would not work like that; a business would know at the start of the year exactly where it is going to find the money.

Ms Thompson: At the start of the year, of course, we have a very detailed process about where savings can and cannot be achieved. Unfortunately, the start of this year — and I guess you are going to say, "The start of last year and the year before that" — did not find us in a balanced position. It is not as though we did not have an assumption of where the £185 million would come out, because we did at the start of the year. Our assumption is that that will still come out in the manner in which it was expected to.

The problem is that that £185 million did not address all the cost pressures that we had also identified. That is where looking for a bit more and a bit more comes through during the year. Yes, it is challenging, but you are under 1% of the budget, and it is difficult. I would prefer to be in a position whereby, at the start of the year, I could say that we are all in balance and everything is OK, but it is not like that because the pressure on the budget is so strong.

If we could have identified £200 million-odd of savings at the start of the year, I would have said, right from the start, "That is great, we have a balanced budget and as long as we deliver to it, we will be absolutely fine". Unfortunately, that is not where we found ourselves at the start of the year, and it is still not where we find ourselves, but I assure the Committee that we are within 1% of that budget. It is built on assumptions, and we monitor those assumptions and ensure that they deliver. The accountability within individual trusts to break even, which is behind a lot of that bottom line that you are talking about, is monitored closely the whole way through the year, and we look for every opportunity to bridge that final gap.

The Deputy Chairperson: I have to say that some very effective and well-managed trusts are saying that, although last year it was deliverable, this year is going to be desperately painful, and they just cannot see how it is going to be done next year. That worries me when people who have always hit targets year after year and taken the pain are saying that they are rapidly getting to the stage where it is almost impossible. I think in year 3, you may not be just as cool and confident as you are this year.

Mr Brady: Julie, to follow the Deputy Chair's analogy about Houdini, you should think about investing in an oxygen tank for the future. *[Laughter.]*

Ms Thompson: I may need one in a minute.

The Deputy Chairperson: It worries me that the people at the coalface, who understand the position you are in, are saying that this is going to get desperately trying in year 3.

Ms Thompson: That is why we cannot just stand still. The demands on the health service continue. In particular, the number of elderly people is increasing and that creates huge demands on the service. Therefore, we have to look at how those services are provided and try to find different models and better ways of doing things. That is where TYC steps in to look at how we can provide those services in a better way for the population, and it also helps us to live within our resources.

At the start of every year, we try to ensure, as far as possible, that we are balancing the books. I accept your point fully: if we can do that earlier, life is a little less challenging during the year. However, I suggest that the trusts are right and things will get more difficult year on year, because, year on year, we are taking out more and more resources.

The Deputy Chairperson: Sue is not here, but I will repeat her point of view: we need to bring this right back to the start of the financial year. Yes, you always manage to pull the rabbit out of the hat and come in here at the end of March and say, "I was kidding. We got the money and everything is fine." However, the process is not efficient. Commissioning plans were issued only two weeks ago, halfway through the financial year. This discussion should be held in April; it should be an Easter event, rather than an autumn one. We were given commitments in the past that this would cease to happen. I would like to think that 2013-14 will be totally different and we will not be sitting here discussing this next September.

If there are no other questions from Committee members, we will move on to the October monitoring round. The same team is dealing with this.

The Department is bidding for £9 million to tackle waiting lists on a range of specialities. The paper states:

> *"The implementation of TYC proposals is intended to deliver additional productivity which will reduce the scale of additional resources required going forward."*

Julie, can you explain what changes will be made under TYC that will result in additional productivity? You have touched on that already, but it is important that we have a look at this within the scope of the monitoring round.

Ms Thompson: It is aimed, obviously, at the acute sector, so we are investing in elective care. I guess that one of the Committee's concerns is that it wants to see investment in services other than those on the acute side. What that sentence is basically getting at is exactly the debate that the Committee has been having: TYC is expected to reduce reliance on additional funding on the acute side and, therefore, will help to manage some of those acute pressures. However, in the meantime, we have significant backlogs on a range of regional specialties. We were fortunate to get £10 million in June monitoring in this area, though we had originally bid for £22 million. We propose to make another bid for £9 million. The bid is slightly reduced, which is just because we are slightly later into the year.

The Deputy Chairperson: How does that improve productivity? I can see why it is welcome funding, but we want to see more operations and more procedures carried out for the money allocated.

Ms Thompson: The productivity issues are around increasing day-case rates, managing and getting people out of hospital more quickly and reducing the length of stay. That is where the TYC link comes in. It is about how we manage those hospital services and move from acute services into community services. That will mean that additional sources that we need for acute services are not as significant. However, for the moment, particularly with the backlogs, we have a significant need for additional resources in elective care.

The Deputy Chairperson: Have you finished on that, Julie?

Ms Thompson: Yes.

The Deputy Chairperson: Peter or Bernie, do you want to add anything? Julie tends to dominate these proceedings, and I do not see you trying to elbow your way in. I think that you are quite happy.

Dr Bernie Stuart (Department of Health, Social Services and Public Safety): I am happy.

The Deputy Chairperson: I will move onto my own hobby horse. You made a bid and were very successful at the last monitoring round. You bid for and got £7 million for the anti-TNFs and additional drugs. That was super because it reduced the waiting lists dramatically. I applaud you for making that application and being successful. It is very much welcomed by those suffering from rheumatoid arthritis, Crohn's disease, psoriasis and a whole range of conditions. Does that programme continue without a further bid in the October monitoring round? In other words, do we go back to where we were because we do not have that extra £7 million?

Ms Thompson: No. That money is still in the system in 2012-13 and the people who are being treated with those drugs must, largely, remain on them. You are quite right: there have been significant improvements in waiting times for specialist drugs. The money that we got in 2011-12 was non-recurrent resource for October monitoring. We have looked at how to sustain those people. It would be completely inappropriate to put someone on a drug and then, on 1 April, say, "I am sorry, I have no money left for you." The people who were being treated in 2011-12 will continue to be treated in 2012-13 and there have been significant reductions in the waiting lists, as was anticipated at that time.

The Deputy Chairperson: But there was no further bid to improve that. It is the case in the Republic of Ireland or in Scotland that, as soon as you are identified as needing those drugs, you go straight on them. Here, we have managed to reduce the waiting lists, which is great news, but ultimately you want to be in the same position as Scotland and the Republic, yet there has been no further bid for that.

Ms Thompson: No, not in 2012-13, but the people who were benefiting last year are obviously still benefiting in 2012-13. When it comes to bidding, as you mentioned, we are allowed to retain flexibility within the budget, but that means that we are not allowed to bid except where major and unforeseen circumstances arise. We would like to register the two bids for elective care and pseudomonas, but we are not like other Departments that can log as many bids as they feel they can spend, effectively.

The Deputy Chairperson: So, our situation has not been brought into line with the rest of the Departments?

Ms Thompson: Not when it comes to bidding. We can bid only for expenditure when major and unforeseen circumstances arise. The elective care bid was viewed in that way in the June monitoring round; hence, we got the £10 million.

The Deputy Chairperson: Who makes the decision that it is something that you could not have foreseen?

Ms Thompson: We make the case to DFP, which, in conjunction with the Executive, decides the outcome of the monitoring round.

The Deputy Chairperson: What are the consequences if the bid is unsuccessful?

Ms Thompson: On the elective care side, you would not be able to treat as many patients in these particular areas. We are saying that we would need the £9 million in order to fully or substantially deliver the targets in 2012-13.

The Deputy Chairperson: Do we have any options on the pseudomonas bid? The report made it very clear that we simply had to act. Will that money be found anyhow if it is not found in monitoring?

Ms Thompson: The Minister is committed to delivering the pseudomonas recommendations. Most of them must be done and done now. Those requirements were not factored into our budget as we started the year, but they represent a significant resource, and that is why, in our opinion, they fit into the major and unforeseen category.

You asked what would happen if we did not get the funds. We would then have to look in the budget. You are quite right: the items that are inescapable would be added to the deficit that I described, and

other things would have to change. Other colleagues across the Department would have to look at the recommendations to see whether any of them could be phased — that would not be my call. To the extent that they cannot be phased, we have to live within the resources that we have got.

The Deputy Chairperson: Professor Troop's report was very clear on this, and we owe it to those who faced a very difficult situation in the wake of the pseudomonas outbreak to make certain that we implement all the recommendations, which the Minister is committed to doing.

Ms Thompson: From that perspective, it very much fits the major and unforeseen category. It is an essential expenditure that needs to be incurred.

The Deputy Chairperson: I am going to throw this open to members, but I want to go back to a point that I made earlier. In your budget, have you assumed a certain level of success in the monitoring round or is this entirely a windfall that is extra to the Department?

Ms Thompson: If we got the £9 million for elective care, it would allow us to substantially meet targets. If we do not receive it, that will create problems for the delivery of elective care targets. As regards pseudomonas, if we do not get that money, it will increase the gap that we have to deal with and will create pressure in other places.

The Deputy Chairperson: Is there already £9 million in the budget on the assumption that you will be successful?

Ms Thompson: No, you cannot spend money that you do not have. We would not book patients in for delivery until we know that we have the money. We have had the debate in the past about knowing early what money you will get. The money that you get in June is a lot easier to spend than the money you get in November, which, in turn, is easier to spend than what you get in January.

Mr McCarthy: I have a couple of questions. The submission refers to the reduction in the requirement for domiciliary care packages. That has been a topic of discussion in Committee before. I welcome the increase in the reablement schemes. However, I would like an assurance that all the older people who are not on reablement schemes but need domiciliary care packages will be supported appropriately. In other words, will no one who needs the packages slip through the net? That is a very important question. Julie, you spoke earlier about the increase in the elderly population.

Secondly, at what point will integrated care partnerships be in a position to reduce hospital admissions and attendance at A&E?

Ms Thompson: All elderly care patients are assessed by individual trusts. They go through those assessments and are kept under review. That determines their level of need and the extent of the service that they require. The reablement model is being rolled out across all trusts. It is one of the strong proposals of Transforming Your Care that helps to manage elderly care demand.

Integrated care partnerships are about managing patients and clients before they go into hospital and ensuring that they are managed more appropriately by GPs and the community. As we debated, you would expect an element of that to start in 2012-13 and even more of it to happen in 2013-14. The problem with these things is that the services need to be in place with primary care and the community before you can take the services out of the hospital. We will have to work through that in a transitioned way over the next few years.

Mr McCarthy: I will go back to domiciliary care packages.

The Deputy Chairperson: Kieran, I am allowing you a bit of latitude; this is not germane to the monitoring round. There is not a huge number of members wanting to ask questions, but this refers to the previous hearing. I will let you go ahead because we have a bit of time.

Mr McCarthy: Thanks very much. There is a fear that there will be people, particularly in rural areas, who will be missed out and overlooked. We all know the repercussions of that. They will end up in hospital, which is something that we are trying to avoid. That is a real concern. I am sure that other members know that the criteria for packages changed. I am thinking particularly of community meals and meals on wheels. You have to reach a very high pitch before you get community meals and meals on wheels, and the result will be elderly people in hospital.

Ms Thompson: Hence, the Transforming Your Care proposals that seek to address that.

The Deputy Chairperson: The bid is £9 million plus £5 million.

Ms Thompson: It is plus £5 million for capital.

Mr Dunne: The bid for capital this year is £330·9 million; is that right? Is that committed to projects?

Dr Stuart: Yes, it is mainly committed. The situation that Julie referred to with the monitoring round does not apply to capital. Capital does not have to be related to major and unforeseen circumstances; we can bid for capital as any other Department can. Most of the money is already committed. We are waiting for a few business cases, which we expect towards the end of the year, and the money cannot be committed until those are through. It is certainly profiled. The vast majority of it is committed to major projects or to ongoing projects such as those involving information and communication technology (ICT), which run through the year, and fleet replacement, which is a rolling programme. A small amount is not yet committed because we are waiting for approval.

Mr Dunne: That will reduce significantly over the next couple of years.

Dr Stuart: This year's figure is so high because there was a one-off payment for the South West Acute Hospital of £100·4 million. That was an additional payment, and, because of the way that it was funded through PFI, a one-off payment was required. That was added at that time. If you were to take that out, that would make that year more or less equivalent to the other years.

Mr Dunne: Sorry, what was that for?

Dr Stuart: It was a PFI project for the South West Acute Hospital.

The Deputy Chairperson: The new hospital, Gordon.

Mr Dunne: I did not catch the name of it. A further bid of £5 million was necessary for various issues.

Dr Stuart: Yes. That is the maximum that we think would be possible to spend. There is always a longer lead-in time for capital expenditure. It is for equipment, some risk-management in the estate, some ICT and the possible purchase of a site. That depends on getting those business cases through. What we have listed here adds up to more than £5 million. We anticipate that, if we get that, we should be able to spend it as soon the approvals come through.

The Deputy Chairperson: We were at the new hospital last Wednesday, and it is extremely impressive. It is an amazing facility, and the people of Fermanagh must be absolutely delighted with what they have. That cost £279 million. You did that on a PFI project over, presumably, 25 years.

Dr Stuart: As far as I recollect, it is 30 years.

The Deputy Chairperson: You have decided to make a one-off down payment of £101 million. Presumably, that reduces the payments over the next 29 years.

Dr Stuart: Yes.

The Deputy Chairperson: Does that then produce extra money going into the capital budget, which can then be spent on —

Dr Stuart: No. There was a complex analysis in the business case, and the options were to have it funded totally through the unitary payment, which is the annual payment, or totally funded through capital. This one-off cash injection is, as you say, like a down payment, which will reduce the ongoing unitary charge. In budgetary terms, it is called off-balance-sheet expenditure, so you do not have to put the other £173 million out of the £273 million onto the balance sheet and it does not hit the capital budget. It does hit the running-cost budget, so that unitary payment is lower than it would have been if it had been totally funded through PFI.

The Deputy Chairperson: Does that represent a slight windfall in that there is extra money because we made the —

Dr Stuart: No, we did not have the money in the first place.

Mr McDevitt: We are off on a tangent, but it is an important observation. It represents a hit to the resource budget. We have passed paying for the hospital from being a capital payment to being an ongoing resource cost. Speaking politically, that is the problem with PFI projects.

Dr Stuart: You either pay for capital or you pay for revenue. In this case, we are paying a significant amount for the next 30 years.

The Deputy Chairperson: It is a lower payment because of the one-off payment.

Dr Stuart: It is lower than it would have been if it had all been funded through PFI.

The Deputy Chairperson: Are there any other questions, specifically on the monitoring round? We have wandered into Fermanagh and a few other places, but we are really supposed to be discussing the monitoring round money for pseudomonas, the £5 million for capital and waiting lists.

If you are successful in the monitoring round, which trusts will benefit?

Ms Thompson: I suggest that, on the revenue side, all trusts would benefit, but that would have to be worked through. Orthopaedics is not necessarily done in every organisation, but it is not just one organisation that would benefit but organisations across the board.

The Deputy Chairperson: Would the funding be spread amongst all five trusts on a pro rata basis?

Ms Thompson: It would be spread against where the profile is on elective care, where the waiting times are and where the numbers of patients who need to be treated are. Funding for pseudomonas would be based on where the neonatal units are. It would be spread not on a mathematical formula or pro rata but based on the need in the individual trusts.

Mr Toogood: We sought information from trusts to determine where the need is so that it can be directed.

Dr Stuart: It is the same with the capital budget, although, in the main, the money would go, by chance, to the South Eastern Trust because of the bids that have come in and the ability of that trust to spend more quickly. The general capital funding is spread across the trusts.

The Deputy Chairperson: Presumably, you are spending the bulk of that at the Tor Bank site.

Dr Stuart: Hopefully, if the business case is through in time, yes.

The Deputy Chairperson: It is unusual to see money being spent on a car park in the present economic situation. Could that not be leased on a temporary basis?

Dr Stuart: That will be evaluated in the business case. It may be that a lease will come out as a better option. In any event, that site is likely to be needed in the future. It was originally part of the Ulster Hospital site. Although it may become a car park, options will be considered for the future provision of services on that site. It was originally part of the site anyway, so it would probably be planned into the strategic direction for the future, possibly not as a car park, but certainly there is a need for car parking spaces there, as you can see if you drive up to McDonald's at any time.

Mr Dunne: Exactly. Go for it.

The Deputy Chairperson: Are there any other questions?

Thank you very much. Julie, no doubt we will see you later on. You are well out of that tank already, and I hope that you will escape once again.

Ms Thompson: Thank you very much.