Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Resource Accounts 2011-12: DHSSPS Briefing

30 January 2013

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 Roy Beggs
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr Conall McDevitt
Ms Maeve McLaughlin

Witnesses:

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

The Chairperson: Members have received a briefing paper from the Department. Thank you for that, Julie. It is useful to have some information prior to the meeting. Julie, I will hand over to you and Peter to give a presentation, and I will then open up the meeting to questions or comments from members.

Ms Julie Thompson (Department of Health, Social Services and Public Safety): Thank you for the opportunity to provide evidence to the Committee on the Department's out-turn results for 2011-12 and for your interest in the key aspects of the future spending patterns as a result of Transforming Your Care (TYC).

Starting with the actual expenditure for 2011-12, the analysis presented in the briefing paper reflects the closing expenditure position of the Department and its arm's-length bodies (ALBs) at its final out-turn. It incorporates the impact of in-year budgetary movements, such as the outcome of monitoring rounds. As we have discussed at previous Committee meetings, the Department's current expenditure overall underspend for 2011-12 was £13·2 million, or 0·3% of its total budget. That is an exceptionally low percentage, which continues the strong performance noted over recent years.

Against that background, I would like to outline some of the areas set out in the briefing paper. The first table shows the out-turn by programme of care (POC). That analysis has been extracted from the trusts' financial returns and, as that suggests, represents the spend from the trust side only. It does not include the direct spend of either the board or the Public Health Agency (PHA), which is contained in a later table. There is a total spend of £3·2 billion for 2011-12 across the nine programmes of care

for the delivery of hospital services and community and personal social services (PSS). That represents 73% of the Department's total spend in that year. Within that, the acute programme of care amounted to £1·3 billion, or 41% of the total actual trust expenditure. That POC includes accident and emergency, surgery, cancer care, intensive care, etc. It represents a significant proportion of the key services provided by Health and Social Care (HSC). Elderly care is the second largest area of expenditure by programme of care, accounting for almost 23%, or £740 million, of total spend. That captures spend across hospital, community and PSS sectors, including nursing support, allied health professionals and domiciliary and nursing-home care. The remaining POCs typically range in value between £100 million and £200 million. On health promotion and disease prevention, it is important to note that the moneys set out in the table do not reflect total spend in that area, as the table reflects only the spend by the trusts. The direct spend of the PHA also needs to be taken into account. When that is done, the spend amounts to over £90 million in 2011-12.

The next table shows that expenditure on family health services amounted to £820 million in 2011-12, approximately 60% of which was on pharmaceutical expenditure. It includes expenditure of £223 million on general medical services.

The third table sets out the Department's direct spend and includes the Department's running costs. These have been reducing over recent years, which reflects a downward pressure being exerted on this area. It also includes the centrally managed budgets, which include a range of budgets, such as clinical negligence payments, vaccinations and other health protection matters. The Department's direct spend includes education and training costs for nurses, allied health professionals and social work.

Finally, the £309 million spent by the Department's other ALBs, excluding the trusts, represents approximately 7% of the Department's final out-turn for 2011-12.

The Committee also expressed interest in Transforming your Care. As members are aware, a key financial objective in the 'Transforming Your Care' report is the intention to shift approximately 5%, or £83 million, of recurrent funding in real terms from hospital-based care to primary and community-based settings by March 2015. This means that spend is anticipated to increase in personal social services, community services, primary care services and family health services. The briefing paper highlights the fact that the shift left might not be immediately apparent at the high level of the analysis that we have set out for you in this paper. That is because hospital services not only span acute services but are present within other programmes of care. Obviously, there will also be a requirement to continue to address inescapable pressures in POC 1, which is acute services, such as those in specialist hospital services and high-cost drugs. The intention, therefore, is to set out the extent of resources being shifted through the Transforming Your Care proposals in the board's commissioning plan for 2013-14.

I am happy to take questions.

The Chairperson: Thank you, Julie. The figures show that 41% of the budget went to the programme of care for acute services and 5% went to the programme of care for maternity and child health. That seems like a big difference. Have you an explanation for that?

Ms Thompson: The acute services programme of care encompasses the full range of hospital services. However, the maternity and child health programme of care incorporates only obstetrics and other elements of community child health, such as health visiting, and so on. The two programmes of care differ completely in the extent of their coverage. The figure shown for investment in acute services includes money spent on waiting time initiatives, specialist drugs, new capital schemes, and so on. It, therefore, continues to increase. Expenditure on maternity and childcare has also increased. That reflects pressures in the hospital side, where, as you will be aware, obstetrics services are under pressure, and investment in the community side on maternity and child health. You are right in saying that the two POCs are completely different.

The Chairperson: I appreciate that and the fact that, in general, women will fall into the acute sector. However, I am struck by the fact that spend on maternity and child health is only 5% of the Department's overall budget, compared with 41% spent on acute services.

Ms Thompson: You are right to say that many women are treated within the acute services POC. The only elements within the maternity and child health POC have a very narrow scope: obstetrics and gynaecology come under that heading. The focus in the community side is on distinct children's

services. There is also the family and childcare POC, where the likes of adoption and foster care lie. There is also significant investment in children within the family and childcare POC.

The Chairperson: I am glad that you mentioned family and childcare. As you say, it has experienced one of the greatest increases, 14·3%, over the four years. Given yesterday's comments from within the judicial system about children in care, is there a specific reason for that?

Ms Thompson: From the financial side, this comes back to when we were bidding during January monitoring. The Committee will recall that I talked then about family and childcare pressures. There is certainly an increase in spend on foster carers, family placements and the whole personal social services side of family and childcare. That is continuing, as you say, right through to the present day, even though this analysis for the Committee is only up to 2011-12. There is certainly increasing spend coming through in those areas.

The Chairperson: Let us move on to health promotion. The vision of Transforming Your Care is one of going back to community level. It is about prevention, education, and so on. The overall percentage spend has gone down from 1·6% to 1·4%, so explain how you see this fitting in to mark II of Investing for Health or the Fit and Well strategy. I assume that you cannot be content that trusts are spending less on health promotion, which goes against what the Department wants to do.

Ms Thompson: I guess that part of the explanation comes from the fact that the analysis shows only trust expenditure. In the period shown in the analysis, the PHA came into existence. Therefore, there is spend coming directly from both the PHA and the board. The Committee will be aware that spend on the PHA has increased. From 2010-11, PHA spending was increased by £8 million by virtue of the allocation that it received and also by the Programme for Government commitment to invest a further £10 million in public health over the years to 2014-15. You are absolutely right to point out that health promotion is key to Transforming Your Care and to ensuring that we can manage to provide services and live within our budgetary and other constraints. Recognising that more and more money is going out directly from the PHA, when we do the same analysis for the Committee for 2012-13, we will be able to show how those two are connected. I appreciate that you are seeing in our analysis a spend of between £44 million and £46 million, whereas the true spend is over £90 million. A large portion of that is direct spend by the board or the PHA. We need to show that more clearly, and we intend to do that for 2012-13.

The Chairperson: I know what you are saying, but I do not agree because the PHA is a non-departmental body, so it takes its guidance from the board and the Department. Without going back over it, I think that you will remember the issue with domiciliary care and meals and wheels: the Minister sent out a circular, but some trusts chose to ignore it. It strikes me that, whatever the Minister comes off with and whatever the Department says, the trusts, which are there to deliver, have decreased the percentage spend of their budget on health promotion. So you can have high-level statements and additional money from the PHA and the board, but, when it gets down to the community and grass roots, the trusts are not complying. How does that fit in? Who controls what the trusts do?

Ms Thompson: The control of the trusts is about managing their financial positions and ensuring that they all break even. What they do and what they deliver are managed through the commissioning plan process. The commissioning plan direction and Programme for Government commitments are set by the Minister, and they work through from there.

The Chairperson: Let me ask you a different question: as you sit here now, would you like trusts to spend more on health promotion?

Ms Thompson: I agree that the drop in spend does not seem to fit well with an increasing trend of health promotion. What I can see, however, from the overall numbers, is that the investment has increased between 2010-11 and 2011-12, and it is intended that it will increase again. I get what you are saying, Chair.

The Chairperson: So you agree with me.

OK, we will talk about mental health. I do not need to go through the mental health issues, especially the increase in suicide and self-harm. As an overall percentage, spending on mental health has gone down from 7·5% to 7%. Who made this decision? Is it another of the trusts' policies? Despite the

Minister's commitments on mental health and associated illnesses, we find that spending by the trusts has gone down again.

Ms Thompson: That also comes back to the overall management of the trusts, which is to do with the commissioning plan direction and the commissioning plan that sits below that. Again, there is investment directly from the board and the PHA in mental health, particularly, as you will be aware, in suicide prevention. The trusts' spend on mental health has increased slightly, by some £6 million. From the trusts' figures, we can see that there has been a shift from hospital services to community services. Trusts' hospital spend has dropped by £7 million, and community spend has increased, with investment in community addiction teams, community psychiatric nurses (CPNs) and consultant outreach teams. That is consistent with the direction of travel. You will be aware of the targets for resettlement and the need to resettle long-stay patients. That is coming through in the numbers. However, spend on mental health is not increasing at the level that, for example, the Bamford review proposed.

The Chairperson: I do not want to be too negative or always sound negative. However, I have a concern that the money coming through the board, the Department or the PHA for specific projects, one of which is a mental health project, is never additional money because the trusts are pulling back on some of these programmes. I have highlighted two programmes of care to you, one for health promotion and one for mental health. Whatever the Minister's policy or in whatever direction he wants to go, when it gets to the point of the trusts delivering elements of his policy, they reduced the money going into those POCs. Are you saying to me that the commissioning plan is not clear enough for the trusts?

Ms Thompson: No. As you will be aware, the commissioning plan sets out a range of targets that the trusts need to achieve and that Northern Ireland needs to achieve regionally, as agreed with the Minister. Trusts are accountable for that and for their performance in that area. Investment is being made in mental health and learning disability. However, there are also issues with reductions for resettlement. When the hospital side goes down, the community side goes up, and the net effect is that nothing much has really changed.

We do pick up direct spend by the board and the PHA, but that is not reflected in the numbers that you see in this analysis. So we need to add in that spend so that the jigsaw puzzle becomes clearer and the true trends come across to you. You are right, Sue, that the increase in investment in mental health is not at the level that Bamford wanted.

The Chairperson: You may remember, Julie, that a criticism from a number of members has been about the lack of information, which we wanted so that we could have that read-across.

Ms Thompson: Absolutely, which is why will pick up on that for the 2012-13 analysis. It is part of the process that we are working on with the board and the trusts for 2012-13.

The Chairperson: It seems to me that senior officials in the trusts — I could be wrong — get together because, across the board, the percentage spend on health promotion and mental health, to name but two, has gone down. It that because they are soft targets?

Ms Thompson: All I can say about the management of money is that the trusts are held accountable across a wide range of issues. They are held accountable by us and the board for the whole ambit: service delivery, the use of financial resources, governance and patient safety.

I can understand, from the Committee's perspective, that investment in those two POCs in particular is not increasing in the way that you would like. The figures that we have given you for the trusts do not show percentage increases. There is, however, more to the story because more money is going in directly from the PHA and the board. That is a factor. Equally, however, spend is not increasing at the level that you would like.

The Chairperson: We have devolved government here, a Minister who is accountable and we are all accountable to our constituency. Does the Department have a vision of how the money should be spent? Do the trusts then deliver that vision, or do they get their money and just spend it how they like? Is there is no accountability at that level?

I will let other members in after this question and come back with further questions later. Just last week, we received a report on suicide across the island. The Minister was at the launch of that report. Suicide is one of the biggest killers, but we are being told that the budget for mental health and related issues has been cut right across the trusts. How does that fit?

Ms Thompson: The budget has increased a little between 2008-09 and 2011-12.

You asked a broader question on what trusts do with their money. What happens is that the wide-ranging pressures are considered at the highest level. As I know that you appreciate, many different priorities fall on the health budget. Those cut across from the basics of pay and non-pay through to demographic pressures requiring more elderly care and specialist drugs. Mental health and learning disability are picking up investment. However, those POCs are quite small, so it would take a much greater shift in the amount spent on acute services to make a difference. You made the comparison, Chair, between the £1·3 billion for acute services and a £200 million programme of care. You could turn that round and say that a bit of investment in mental health would, hopefully, do more. However, it takes a lot to disturb the percentages, simply because such a high proportion of the spend is on acute services.

So the pressures, which are many and varied, are examined at the highest level across the whole ambit, and money is then given to the trusts. They have to deal with the moneys that they have; balance their financial position; deliver the performance set out in the commissioning plan direction; maintain the safety and quality of patient care; and ensure that their governance arrangements are appropriate. That is the guide, or framework, within which trusts operate. They balance the money allocated to them, which has been assessed across a range of competing priorities. That is all set out in the commissioning plan, as you will see in the 2013-14 plan when it comes through. From there, trusts take the money and deliver against the commissioning plan direction's targets. That is how the process works, and they are held accountable for it.

At the end of the year, we assess the financial splits according to programme of care. The analysis is not done month in, month out. That would not be possible.

The Chairperson: I will come back to my other questions.

Mr McCarthy: You have covered most of my concerns about the health promotion and disease prevention programme of care. The figures show a decrease of 6% over the four-year period. That does not encourage me at all, though it is better than before. It is not that long since money had to be sent back because you were unable to spend it. You mentioned that the true spend on this programme of care was £90 million. Why was that figure not included so that we could absorb that information rather than having to ask you about it? Do you just like answering our questions? *[Laughter.]*

Ms Thompson: The analysis is based on the trusts. We recognise the interest of the Committee in health promotion. This analysis does not give you the full picture, which is what we want to provide from 2012-13, particularly as the PHA has become an increasing player financially. We need to ensure that the Committee can see that, and that is what we intend to do from 2012-13. That will be a refined process, and we will, of course, keep trying to improve it. The direction of travel and the questions that the Committee are asking are very clear, and we are trying to refine the analysis to deal with the issues that you raise.

Mr McCarthy: You must agree that health promotion and the prevention of disease are key to what we are trying to achieve, particularly through Transforming Your Care.

You said that expenditure on learning disability had increased by 15% over a three-year period. What do you expect in 2012-13? Is there any money included for increased respite facilities, of which, as we so often hear, there is a lack in the community.

Ms Thompson: We expect the budget for learning disability to increase again in 2012-13; not necessarily by a significant amount, but some increase should still come through. Learning disability still shows the same sort of trend as mental health, in that there is increasing investment in the community side of the piece and a reduction in the hospital side. The whole agenda of moving that on has certainly been picked up.

Mr McCarthy: Is there any funding to increase respite opportunities for people who need them?

Ms Thompson: I do not have a respite analysis here. We can see whether we can get it, but it will depend on the level of detail that we have. However, I will see what we can get for you around respite and come back to the Committee with the information.

Mr McCarthy: That is fine. I want to emphasise what the Chair said about the Bamford report, and you mentioned it also. As I understand it, the Bamford report is behind already, and if you do not invest, it will get further behind. Those of us who are interested in mental health want to make sure that we do not fall any further behind.

Ms Thompson: Absolutely. Those are the same issues that the Chair raised.

The Chairperson: Julie, in your answer to Kieran, you said that you expect the learning disability budget to increase. Does that mean that you are going to direct the trusts to increase it?

Ms Thompson: Kieran was asking me about 2012-13, and 2012-13 is nearly complete. In the commissioning plan, it is the same issue around setting out where money is planned to go — hence my answer to Kieran. The question is this: what is to be achieved with that? There are obviously resettlement targets. There are also discharge targets around mental health and learning disability to ensure that we are not only resettling those long-stay patients but moving people through the system so that they are not getting stuck in it. That is all part of the commissioning plan direction, and you will see that equally in the 2013-14 commissioning plan direction as a ministerial direction to the trusts and the board.

The Chairperson: When will we get that plan?

Ms Thompson: I am not clear on the exact date, but soon. It is being worked on at the moment. I know that the Committee has had concerns about timeliness in the past. However, I am aware that it is significantly being worked on, and, therefore, "soon" means in the next few weeks, or March/April at the latest.

Mr Wells: Are you saying that there is a commitment that we will not be looking at the commissioning plan in the year in which it is being implemented? We will actually see it before that year starts? We are at the end of January, so I would like to think —

Ms Thompson: That is why I am saying that I know it is very significantly in development, and, therefore, I expect that the Committee will see it soon.

The Chairperson: The end of January is tomorrow.

Mr Wells: You never know.

The Chairperson: Who knows? Stranger things have happened.

Mr Brady: Thank you very much for your presentation. My questions have been asked already and probably answered.

There is an increase for mental health, but it is a marginal one of 2·8% over the four years. Bamford has been mentioned already. If it ever, ever comes to fruition or implementation — we have been talking about it since I came here in 2007, and nothing of any significance has happened — do you anticipate that proper spend will be included in the implementation of Bamford? It is a very comprehensive and wide-ranging report. People have talked about housing, mental health and all sorts of things, but, to date, nothing appears to have happened. We have talked about it a lot, but we have never really entertained it as such.

Ms Thompson: I guess that there are the same issues involved. There are certainly targets around resettlement. For 2013-14, we are talking about resettling 75 long-stay patients from learning disability hospitals and 23 long-stay patients from mental health hospitals. Equally, it is about ensuring that no delayed discharges happen, and that those are managed. On the translation of that into the financial side, I appreciate that the levels of increase are not as significant as Bamford set out. There has been more investment in learning disability than in mental health. The other thing that I will

say is that we can definitely see a shift from hospital services to community services, which is in line with the policy direction in Bamford. However, we are a long way off the £400 million of finance in the Bamford review.

Mr Brady: Some of us sit on the Committee for Social Development, and housing is an integral part of Bamford as well. Are you aware of any interdepartmental discussions about implementation and, indeed, budgets, that are realistic for Bamford?

Ms Thompson: I am not au fait with the detail, but I know that discussions are ongoing with DSD around the supported housing-type concept and all of that. However, I do not know the detail.

The Chairperson: Just for information, a number of weeks ago during Question Time, the Minister for Social Development accepted that he is failing on his commitment under Bamford around supported housing. It might be an idea to check that out.

Mr Dunne: Thank you, Julie and Peter, for coming along today. I have a couple of things to say. Is there any intention of bringing forward any new moneys for Transforming Your Care?

Ms Thompson: In 2012-13, we received £19 million in transitional funding for TYC and other HSC savings initiatives. That money is being spent through 2012-13. You will be aware that the TYC report set out the need for £70 million in transitional funding over the period 2014-15. We are looking at that for 2013-14 and 2014-15. At the moment, it is fair to say that we have not identified a funding source for 2013-14, but we are still working through the full ambit for all 2013-14. As the Committee may recall, the previous time that I was here, I suggested that we would want to come along at the start of the next financial year and go through the 2013-14 position with the Committee. Yes, there is a need for more transitional funding for TYC to secure its delivery. As yet, that has not been fully identified for 2013-14 or 2014-15.

Mr Dunne: The 2013-14 year is not far away, really. It is two months or so. There are issues that need to be addressed.

The main source of funding will come out of hospital care. Is that not a risk and a concern? We local representatives feel that the big issues concern waiting lists for acute services. Our mail is mostly about delays in operations. People really feel that that is where the greatest need is. Is there going to be more pressure on those areas as a result of the proposed funding for Transforming Your Care in the incoming year?

Ms Thompson: You are quite right in saying that there is tension on priorities and pressures all over the budget. Acute services has its own version of those pressures. It is the same for mental health services and health promotion. Dealing with your question, I can say that the TYC proposals are about ensuring that there is adequate provision in the community to reduce the spend in acute services. That has to be done appropriately, and that is why transitional funding is necessary to support it. Initially, we would expect an element of double-running before we can take down the acute service provision. That has to be done carefully, managing safety and the quality of care for patients and ensuring that they get the right and appropriate provision. In the meantime, we have to, as you say, continue to deal with waiting times and ensure that people are being appropriately treated and able to get access to treatment. It is the ambit of all of that that is worked through in the budget analysis but with the plan that, by 2014-15, moneys will have shifted from one area to the other.

We are going to ensure that, within the commissioning plan, there is a clear articulation of that. How money will transfer in Transforming Your Care has been clearly set out in sufficient detail in the commissioning plan direction, because at a programme of care level you will not necessarily see it. We need the detail below it, and that is part of the commissioning plan expected for 2013-14 — to see to what extent that shift happens in that financial year. That will obviously be repeated in 2014-15.

Mr Dunne: Is part of that funding likely to go to GPs, who, as I understand it, will get additional work and duties and more responsibilities and, what we all want, take on the workload of A&E departments?

Ms Thompson: Funding will go to a range of areas. The Committee will be aware of integrated care partnerships and their centrality to the TYC proposals. GPs will be a significant part of the integrated care partnerships. There will be money to help support those happening and to ensure that patients

ultimately benefit, outcomes are improved and the whole process is more effectively managed. There is an element of funding for that. There is an element of funding for service change on the acute side. As you have already pointed out, the acute side needs to change as well. There is a range of areas in which we expect funding to be needed.

Mr Dunne: Finally, at tab C in your briefing paper, education and training costs seem to be an area of concern. Does that mean that there is a lack of funding, or there is likely to be less funding, for the training of health professionals and to bring new people into the health service generally?

Ms Thompson: There has been a need to look at training in general and to ensure that the workforce is appropriately trained, particularly for new models of care. A regional workforce group has been established to look at that specifically to ensure that training, if people potentially need to change how they do their jobs — retraining, if you like — is able to be provided. Therefore, you are quite right. It is something that needs to be consistent with the change and that ensures that the adequate number of people are being trained in the right areas and the right disciplines. That presumably means increasing the element that would support community-style provision rather than acute-style provision.

Mr Dunne: What about Transforming Your Care? People will need to be trained or retrained.

Ms Thompson: Absolutely.

Mr Dunne: From where will the funding for that come?

Ms Thompson: That is an adaptation, if you like, of existing training budgets. The regional working group under Transforming Your Care is looking at that currently.

Mr Dunne: It is decreasing.

Ms Thompson: I appreciate that. What the group needs to do is to look at and identify what training needs to be provided — who needs to be trained and exactly what they need to be trained in. A working group is looking at that, particularly with an eye on TYC and what that might mean for future training needs.

Mr Dunne: My final point, Chairman, is on a general issue. All being well, we will debate annual GP health checks next week. What if GPs and their organisations turn around to the Department and say, "Fair enough, but we need additional funding." Will that funding be available or will you say that it will come down through TYC? I know that the Chair will say that they are already getting paid for doing it, so they should be doing it.

The Chairperson: To add to that, when you look at the figures, you will see that funding for GPs has gone down but has increased for pharmacy and dental services. Can you also explain that, especially when you hope that with Transforming Your Care more funding will be going into primary care?

Ms Thompson: You are quite right to ask how we invest in primary care. What it actually means to deliver the Transforming Your Care agenda is absolutely vital. To ensure that GPs, pharmacists and the whole gamut, if you like, of primary-care professionals are supportive of that work is essential throughout TYC. The GP contract stuff is still being worked through. It is nearly finalised, as far as I am aware, on the GP side. We will liaise with GPs shortly on that.

Mr Dunne: Is that related to TYC?

Ms Thompson: It is related to the contract. Other people in the Department are looking to see how you can use and adapt the contract to ensure that what you get out of it is consistent with the TYC policy direction — that it uses existing money in a way that supports the policy agenda.

Could the GPs do annual health checks for everybody? I presume that they would look for significant additional resources in order to do that, compared to the number of people whom they would be treating. I am not aware of what the financial implications would be, and I certainly do not have an analysis with me to support it. There would be a pressure from that, absolutely.

The Chairperson: It can be done, however.

Ms Thompson: I am sure that you will all be debating it next week.

Mr Dunne: Thanks for your answers.

Mr Wells: Some of my questions may be on a slight tangent. You have everything at your fingertips. Last time around, I created the analogy of your being like a female Houdini just getting out of the water-filled tank at the last moment. I assume that you are here to report that you have done it again this year.

Ms Thompson: Not quite. Then again, it is not the end of the year yet. We still have an element of deficit that we need to resolve. We are working hard at doing that between now and the end of the year, but we are not there yet. It is the end of January, not the end of March.

Mr Wells: You are quietly confident that you will have it in the bag, however?

Ms Thompson: We are working exceptionally hard to ensure that we can bring it in on balance. Absolutely.

Mr Wells: That is a yes. I want to go back to the real subject that we are discussing. This is a technical issue. It may not be in your field, but it is worth asking. A large proportion of the expenditure on the new South West Acute Hospital was spent in 2011-12; indeed, it opened in June 2012. A large element of that expenditure came in that financial year. When we visited the hospital, we discovered that, instead of it being paid for over a 25-year period, a large part of the cost was paid in one fell swoop. Did that expenditure come from resource or capital?

Ms Thompson: The one-off expenditure came from capital, while the 25-year expenditure comes from revenue.

Mr Wells: Therefore, you are still left with an element to pay for that hospital?

Ms Thompson: Absolutely, but it is not as big as it would otherwise be.

Mr Wells: That begs a question that, again, is not specifically in your field, but it has to be asked. How on earth will you be able to find £100 million out of capital to pay that in a year when there are so many pressures on that budget?

Ms Thompson: You are quite right. I am not responsible for the capital field, but, having said that, the South West Acute Hospital has been factored into the capital budget as a requirement for quite some time, both at our level in the Department and at Executive level. There has been a significant awareness that such a significant amount of money was needed for that hospital in that particular year.

Mr Wells: I was hoping that you were going to tell me that that was a windfall that has freed up the equivalent annual payments on the hospital from the revenue side.

Mr Peter Toogood (Department of Health, Social Services and Public Safety): That amount was factored into our four-year budget back in 2010 when the budget process happened. It was anticipated and put into the budget by DFP and agreed by the Executive.

Mr Wells: Therefore, there was no windfall on the revenue side as a result of that decision?

Ms Thompson: The revenue side that we are paying out for the South West Acute Hospital is less than it would otherwise be if we had not put in that £100 million of capital. We are paying out a lower level than we would otherwise have done. The £100 million has to be found in capital first in order to facilitate that.

Mr Wells: It was foreseen. Therefore, it is not a windfall. It is not extra money that is available to us.

Ms Thompson: Gosh, no.

Mr Toogood: It is part of the entirety of the Executive's Budget.

Mr Wells: Equally, was there an element in 2011-12 for swine flu that was not spent?

Ms Thompson: We had a very small amount of money set aside for swine flu, just as we traditionally carry money to deal with flu. The spend on swine flu was very significant. Some of that was found from within our resources and some was found by other Departments across the Executive. It was a very challenging time for everyone.

Did you ask me whether it creates a windfall?

Mr Wells: Yes, because you would have built it into the budget and did not spend any of it.

Ms Thompson: No. Our budget did not anticipate swine flu to happen at all.

Mr Wells: Therefore, there is no pot of gold as far as that is concerned.

Again, this is probably an unfair question, and if you do not answer it, I will not worry about it. We are all under a lot of pressure because of the discovery of the vaccine for meningitis B. We have all been lobbied about it. That vaccine will probably become available in June. It will be up to the Joint Committee on Vaccination and Immunisation (JCVI) to decide whether that is applicable, and the Minister will then have to decide whether it is applicable to Northern Ireland.

How, in that eventuality, would we find the essential cash needed for such an unusual situation? Has that been predicted in the same way as the other things that you suggested?

Ms Thompson: I am not responsible for that area, but a range of health protection vaccines is already coming on stream from existing JCVI decisions. What tends to happen with those is that there is an agreed roll-out, which determines who gets the vaccine, what age the people are who get it and what scope the vaccines cover. That challenge — the question of to whom to make the vaccine accessible — affects not only us but the entire UK, should that decision be taken.

In looking forward, for example, into 2013-14, although I am not aware of the full details, I know that we are experiencing pressures because additional vaccines will come on stream. However, to go back to the argument that we had at the start of the conversation, it is about health promotion and prevention, ensuring that we invest now in order to improve things for the future.

Those vaccines are being funded in 2013-14, for example, but that has to be managed. The roll-outs tend to be the way in which it is managed, but that creates more pressure on the budget, and the money has to be found. There is never any magic pot of gold.

Mr Wells: Do you have a process in which you look forward to what is becoming available and allocate a pocket of money for that, or do you see whether you can find the money from somewhere else when something comes along?

Ms Thompson: When a Minister takes a decision, we give advice on its financial implications and on how that might ratchet up as roll-out happens over a series of years, if that is the way in which it is intended to be done.

Finding that money has to be factored into the overall position. It is not that we automatically get anything from the Department of Health that would come directly across to the Executive and directly into our budget. Any money coming to here comes through Barnett, and it is then up to the Executive to decide how much we in DHSSPS receive. Therefore, there is not a direct relationship there for direct financing of these things. It gets added into pressures, and it has to be financed. That is the decision that is taken alongside all the other pressures that you have already discussed.

Mr Wells: Finally, 70% of the budget goes on salaries, wages and associated costs. There was a freeze on a large proportion of the pay budget for everyone earning over £25,000, which includes all consultants, doctors, and so on. That is not happening this incoming year. I believe that it did apply to 2011-12.

Ms Thompson: No, there was a freeze in 2011-12.

Mr Wells: Yes, I know. Did the freeze extend to 2012-13?

Ms Thompson: I am not sure. It has certainly been lifted for 2013-14.

Mr Wells: That is the important point. That will have significant implications. A 2% saving on everyone in that 70% bracket who earns over £25,000 is a very significant saving that the Department does not even have to worry about because it is automatic, and it is right across the entire Civil Service and public sector. What are the implications of that unwinding, as far as the future is concerned?

Ms Thompson: You are quite right. We experience increased pressure because of that. Pay inflation has to be factored in. The only positive that counteracts that is that we have additional resources from the Executive in 2013-14 — almost double the amount of money that we received in 2012-13. We take all the pressures, which will include pay, non-pay, acute, mental health or whatever, and we add them all up. As we go into every year, we need to identify savings in order to manage those pressures, alongside the money that is received from the Executive. That is the whole budgetary process that has to be gone through at its highest level. The translation of it today is into the programmes of care where the money falls out. However, you are quite right to say that the more money that is spent on pay, the less that there is available to do new things.

Mr Wells: It also makes it more difficult every year if you have to factor in pay rises as well as all the other rising costs.

Ms Thompson: Absolutely, and if savings have to be added on year on year, which they are being, that gives us a greater challenge every single year.

The Chairperson: There were a lot of probing questions there for future use. I like the Department's attitude that it is preparing for the future, because different Ministers make different decisions, and who knows what is around the corner.

Mr Beggs: Thank you for coming along today. I reviewed the figures for the past year, and I see that a lower proportion of expenditure has been on elder care, mental health and health promotion. I am curious as to how that has happened, particularly for elder care. We have been told that we have one of the fastest growing elderly populations, so how do you account for the fact that we have spent a reduced proportion of funding on elder care?

Ms Thompson: Elderly care as a proportion of the overall budget has reduced, but actual spend has significantly increased, by over £50 million from 2008-09 through to 2011-12.

Mr Beggs: Would inflationary pressures not have —

Ms Thompson: No. There is a significant investment. The £50 million is way above inflation. What is happening in elderly care is as you would expect. We are experiencing drops in hospital service provision on elderly care and increased community services going in. A lot of that is going in to deal with the ever-growing elderly population, as you would expect. Therefore, it is a budget that is continually under pressure, simply because the demographics are continuing to increase, but, at £50 million, that is additional funding going into domiciliary care, nursing care —

Mr Beggs: Can you explain the £50 million? I am looking at 2011-12. The figure is £739·6 million, and the previous year was £721·3 million.

Ms Thompson: I am going back to 2008-09, which was £687 million.

Mr Beggs: I am comparing last year with the previous year. There is a reduced proportion of funding over the previous year.

Ms Thompson: Sorry. I was going right back to 2008-09. Apologies for that. There was an £18 million increase between 2010-11 and 2011-12. It will be funding partly the pay and prices, but, equally, it has the demography in it about the extra portion of care. It is very clear that for elderly care

services the increases are going into the personal social services side of the spectrum — the community side and domiciliary care. That does not mean that there are no pressures in those budgets. There most definitely are, as I am sure the postbag will testify to. However, we have experienced increases in those budgets. You are quite right, Roy. It is dropping as a percentage of the overall budget. Again, I guess that we come back to the same issues where funding is dropping for any of those. There is a pressure coming all over the budget. The moneys are going in. It goes back to Sue's question about how you know whether the trusts are just doing what they like or delivering what they should. It goes back to targets, the commissioning plan direction and whether what was set out by the Minister is being achieved, and that is where the relationship comes in.

Mr Beggs: You mentioned domiciliary care. There is a concern that it is about savings and that the money is not all being reinvested in elderly care in the community. There are concerns that the significant support that should be there is not there. You accept that there has been a proportional reduction in the health budget spent on elderly care over the past year.

Ms Thompson: Absolutely. That is what the figures show. However, domiciliary care has increased by £4 million over the past year.

Mr Beggs: OK. I will move on to mental health services. The figures for 2010-11 and 2011-12 show that a reduced proportion has been spent on mental health. It is not only a reduced proportion, for £500,000 less has been spent despite Bamford indicating that that is an area in which additional expenditure is required. I am aware of concern in the community about child and adolescent mental health services (CAMHS) and the need for better support in the community. How do you account for the reduction in the amount of money going into mental health, despite those pressures?

Ms Thompson: That goes back to a combination of factors. We know that moneys invested directly by the board and the PHA have increased. Therefore, a £4 million increase has happened from that expenditure, a large portion of which has gone into suicide prevention initiatives. Similar to that for elderly care, a switch has been going on in mental health between hospital services and community services, and that goes back to the point that I made already, which is that the moneys going in are not as high as what Bamford suggested but the size of the budget is increasing, and that is consistent with the Bamford policies around community addiction, community psychiatric nurses (CPNs) and the community side of provision. However, I guess that it is accepting what has already been debated, which is that those increases are not coming through as much as the Committee would like.

Mr Beggs: We are nearly at the end of 2012-13. Can you explain why it takes so long for those figures to be accumulated? I would have thought that audited figures from each of your agencies would be submitted probably in June or July. Why has it taken a further seven or eight months for us to get the cumulative figures?

Ms Thompson: We have been looking at pulling that information earlier. You are quite right. The final accounts are done in the early part of July. From then, all the splits need to be done to work down those final accounts, which are at a fairly high level, into all the analysis. We have been working to see whether we can deliver that a bit earlier, but I caution that it will be the autumn before numbers at that level of detail can be pulled out. However, I accept that it is now January, as opposed to October or November.

Mr Beggs: However, the sooner that information is out, the sooner that people can understand what is happening and take appropriate action if necessary.

Ms Thompson: Absolutely. I appreciate that.

Ms Maeve McLaughlin: Thank you for the update. Although I share Roy's views on this, it is slightly frustrating that we are discussing figures that are not displaying the accurate read. I do not think that it is acceptable that we do not have the accurate figures for the Public Health Agency, and I do not accept why it has taken so long to get them. Given the proposal to give an additional £10 million to the PHA, I suggest that that will give us a very different read. It is a bit frustrating to have a discussion around figures that do not give us a proper read. My first query concerns the family and child care programme. The paper states that it has experienced one of the greatest increases. It then details, in paragraph 3, a rise from £180·9 million to £260·9 million, an increase of 14·3%. Paragraph 6, under learning disability, then states that expenditure has increased by 15%. Which is the highest there? It is telling us that family and child care has increased —

Ms Thompson: It says "one of the greatest increases".

Ms Maeve McLaughlin: Is that a mistake?

Ms Thompson: It is one of the higher increases across the programmes of care. The Committee has concentrated, so far, on the ones that are experiencing the lowest. Family and child care and learning disability are the two that are experiencing one of the highest.

Ms Maeve McLaughlin: OK, but it would be 14·3%?

Ms Thompson: I agree that learning disability is higher than family and child care; absolutely.

Ms Maeve McLaughlin: OK, thank you for that.

Has any economic analysis been done on the impact across those eight or nine themes of the proposed shift of the £83 million from acute to primary that is advocated through Transforming Your Care?

Ms Thompson: That is being worked through for the 2013-14 commissioning plan. The commissioning plan direction specifically requires that the financial shifts anticipated from Transforming Your Care are clearly set out. That needs to be at a lower level of detail in the programme of care, which Peter may want to expand on. However, we know that we need to see that clearly as part of the commissioning plan, and the intention is to do that. Peter will explain a bit about how that may happen.

Mr Toogood: The programme of care analysis sets the information at a certain level. The 'Transforming Your Care' report outlined an intended shift from hospital services to community and personal social services. At the moment, the programme of care analysis is that hospital services will cut across a number of programmes of care. As we heard in today's discussion, you have hospital services within acute, maternity, etc. So, we need to do some further detailed analysis below this to demonstrate that, and that is the work that Julie referred to as being ongoing. The board is looking at some key service areas to see how they can be commissioned in a different manner. We outlined it as part of our invest-to-save submission. For instance, how are stroke services treated and could they be treated in a different way that would, essentially, move the expenditure?

Ms Maeve McLaughlin: You say you are looking at key service areas. Are they being collated with the Fit and Well proposals and the health inequalities?

Ms Thompson: The commissioning plan needs to cover all of that agenda, as well as all of the key policies and strategies, obviously, of the Department. So, you will appreciate that you are looking at some of the Fit and Well indicators across a longer period. We also want the commissioning plan to draw out specifically what is happening in 2013-14. We know that TYC is not done in just 2014, so we need to look ahead. You are quite right: the whole lot needs to come together. The Minister sets out what he requires in the commissioning plan direction, and the commissioning plan then deals with the outworkings of that. The Committee will see how the board intends to deliver against the ministerial priorities, which encompass the whole gambit of our policies.

Ms Maeve McLaughlin: I suggest that, within TYC, there is no framework indicating how any of the proposals will target health inequalities or allow us to measure outcomes on the basis of health inequalities. It is just not there.

Finally, the suggested transition funding is £25 million in year 1; £25 million in year 2; and £20 million in year 3. Has any of that been spent to date?

Ms Thompson: That was in the original 'Transforming Your Care' report. It was then reprofiled. We received £19 million from the Executive in the autumn to do with TYC and other savings initiatives. That money is to be spent in 2012-13. So, the answer to your question is yes, money has been spent and will continue to be spent over the period.

The Chairperson: On Maeve's point, Peter, you mentioned the programme care analysis. Who is carrying that out?

Mr Toogood: The board is leading on it with direction and assistance from us.

Ms Thompson: It is part of the commissioning plan.

The Chairperson: So, it is not consultants who are dealing with it. I do not mean medical consultants.

Mr Toogood: No, it is not being done by external consultants.

The Chairperson: So, the board is doing it in-house.

Ms Thompson: The board is working on the commissioning plan and the TYC shifts that you are talking about. I think your question is this: will there potentially be more consultancy around Transforming Your Care? I would suggest that the answer is probably yes, but no business case has been fully worked up for that, and that will be subject to business case approval, ministerial approval and DFP approval, so it is early days as far as that process is concerned. I would suggest that it is likely that more consultancy will be necessary.

The Chairperson: As it sits, the programme care analysis is being done in-house.

Ms Thompson: Yes.

Mr Wells: I raise this every year at this stage of the year, and you always have an answer to me. You always have an answer to everything, actually. With a great deal of expertise, you hit your targets, but there is always a little pocket of unspent money. I think it was £12 million last year. I always ask whether you can have one little project ready to run to eat up that money. Last year, I suggested anti-tumour necrosis factor (TNF) drugs, and you came back with a very well-argued point that procurement does not allow you to spend money in that way. You cannot order essential life-saving drugs in that way, and there has to be a proper tendering process. Over the past nine months, I have been giving some thought on this. What is to stop you going through that whole process but saying to your provider that this is entirely dependent on x amount being available at the end of the year so that you have all the i's dotted and all the t's stroked? You would know then that, if the money were to become available, you could order in those essential drugs or whatever very quickly, but there would be no commitment. Is that a possibility? It does annoy me. If you have £12 million left in the pot from a big budget of £4·65 billion, that is bullseye stuff, but £12 million could make a big difference for new ambulances, fire tenders or drugs. Therefore, is there any merit in considering that?

Ms Thompson: Sitting where I am sitting, the problem is that, with £12 million, or 0·3% of the budget remaining, you are exceptionally tight to an overspend. We do not know definitively where we will land that ship until we have gone through the audited accounts at the tail end of June, by which stage, any option to buy anything has long since passed by. Although I understand the essence of what you are proposing and that that would certainly short-circuit any delay, if you like, in a procurement process, the reality of the situation is that we would be within 0·3% of the budget and would have to run through an audit process with all sorts of risks of anything that might come in that would hit against the budget. The £12 million against a £4 billion budget is a very, very small proportion, and that is why the Department's figures, as a percentage, make it one of the better performing Departments across the entire system. Until we work through that audit process, we genuinely do not know exactly where we will land. Although I appreciate the sentiment, the reality is that you would need to be looking to the end of March and be highly confident that you had got everything absolutely right and that you could afford to spend more money for that to be viable.

Mr Wells: I knew that you would have the answer, so I will think about it for another year.

The Chairperson: Julie, the information that you have provided on departmental running costs shows that significant savings have been made on the Department's direct expenditure. How was that achieved?

Ms Thompson: By significant downward pressure on departmental running cost budgets. It involved stripping out as much as possible and looking actively. We have been running an efficiency exercise

in the Department for all the recent years. We have looking to see what posts we could take out and where we can do things differently. We have been proactive to get a greater focus on front line services and ensure that we can get as much as possible into front line care.

The Chairperson: How much is set aside yearly for clinical negligence?

Ms Thompson: The exact number I cannot give you. It is something in the order of £30 million.

The Chairperson: Does that be used every year?

Ms Thompson: Yes, that budget is under significant pressure. We were at the Public Accounts Committee not that long ago around that. There has been an upward trend in clinical negligence in recent years, for a range of reasons, not least because the courts are dealing with a backlog of cases. As cases understandably get cleared, that is putting pressure on the budget. We have had increases there, and we anticipate still being under pressure in that area, certainly for the next couple of years.

The Chairperson: In the paper, on Transforming Your Care, it says that the vision for 5% of funding moving from hospitals to primary community settings will not be reflected in the future programme of care figures. I know that most, if not all, of us have touched on that. How do you expect there to be transparency and accountability, for us as a Committee and for the public, when looking at the shift in resources?

Ms Thompson: I recognise exactly the point you are making. That is why it has been specifically drawn out in the commissioning plan direction and will be specifically included in the commissioning plan. If you leave it at a programme of care analysis, it will not give transparency. We need to see exactly what is going on. The Minister needs to see what is going on. The Committee needs to see what is going on. So, within the commissioning plan, you will have a subdivision, which will help everybody to see what is going on and proposed to be going on in Transforming Your Care. That has been deliberately put in to allow transparency around what is planned.

The Chairperson: The indications are that the commissioning plan will be available by the end of January, which is tomorrow. Sometimes members around the table have more information than officials, but can you find out for us and let us know?

Ms Thompson: What I can say is that there is certainly a significant draft. Whether it is robust enough —

The Chairperson: Will you come back and let us know?

Ms Thompson: We can certainly come back. It will be available soon, I do not disagree, but I am not entirely sure that it will be available tomorrow.

The Chairperson: Being told you are going to get an operation soon can mean anything up to a 28-week waiting list. But you say soon. OK.

That was quite useful. We are getting better at this, because we are getting more information.

Ms Thompson: We continue to work at it.

The Chairperson: Thanks very much for your time, Julie and Peter.