Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Evidence Session with Departmental Officials on the Northern Ireland Executive Budget 2011-15

9 September 2010

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mrs Mary Bradley
Mr Thomas Buchanan
Mr Alex Easton
Mr Tommy Gallagher
Mr Sam Gardiner
Ms Sue Ramsey

Witnesses:

Mr Martin Bradley	)	
Mr Sean Donaghy	)	
Mr Sean Holland	)	Department of Health, Social Services and Public Safety
Dr Michael McBride	)	
Dr Bernie Stuart	)	

The Chairperson (Mr Wells):

Mr Sean Holland remains with us as we move on to an evidence session on another important issue, the Executive Budget 2011-15, about which members will have quite a few questions. You are all welcome. None of you is a stranger to the Committee for Health, Social Services and

Public Safety. You are here to give evidence on a subject that I suspect will be raised on occasion between now and 20 October. The Committee is delighted that the Department of Health, Social Services and Public Safety (DHSSPS) has sent such a strong team.

We know Dr Michael McBride, the Chief Medical Officer. He is accompanied by Sean Donaghy. Unless there are two Sean Donaghys, I think that you have been recently appointed to a higher position. Is that correct, Sean?

Mr Sean Donaghy (Department of Health, Social Services and Public Safety):
I have been appointed as chief executive of the Northern Health and Social Care Trust.

The Chairperson:
Congratulations. I am sure that our paths will cross in your new role.

Mr Donaghy:
There is no doubt about that.

The Chairperson:
We hear much about dynasties in Northern Ireland. It looks as though another dynasty is rapidly forming. Well done; that will be a challenging position. When do you take up your new position?

Mr Donaghy:
I start on 20 September 2010.

The Chairperson:
Therefore, this is your last time before us as a departmental official.

Ms S Ramsey:
You can tell us whatever you want now.

Mr Donaghy:
I was always frank with the Committee.

The Chairperson:

Also in attendance are: Mr Martin Bradley, the Chief Nursing Officer; Dr Sean Holland, or, should I say, Mr Sean Holland — I am determined to elevate him — and Dr Bernie Stuart, who is from the health estates investment group.

You have sent the Committee some slides and charts, which is helpful. The session will take the usual format. You have 10 minutes in which to give us as much information and detail as you know. I hope that that will clarify the confusion out there about where we stand on the crucial issue of the health budget.

Mr Donaghy:

Ten minutes is a short time, and there is much information.

The Chairperson:

We will give you some latitude if you give us the full figures.

Mr Donaghy:

There is much information, so if you are content, Chairperson, I will run through the presentation and give colleagues an opportunity to amplify on some of the key clinical and social care nursing issues, for instance, before taking questions.

Our previous meeting concerned the 2010-11 account year. Before turning to the content of this presentation, I want to distinguish this discussion on the 2011-15 budget from the significant discussions that we had about the 2010-11 budget. I remind everyone that our previous engagements were about how to make ends meet and how to square Northern Ireland's budget for 2010-11. At that time, we were concerned about the impact that the late budget reductions of £113 million for 2010-11 would have on our capacity to maintain waiting-time standards, for instance, and we shared that concern with the Committee. Unfortunately, some of that has come to pass. That was 2010-11, and, for the purpose of this discussion, that is in the past. We are considering the period from April 2011 onwards and asking what further issues we face as we debate what the likely settlement for health could or should be from April 2011 to March 2015. It is a four-year budget.

The Chairperson:

We have the budget for the current year, and that is that; there will be no changes.

Mr Donaghy:

There is always an in-year monitoring process. Along with every Department, the Department of Health, Social Services and Public Safety will respond to that process, but the budget is set at the start of the year with only marginal changes possible thereafter.

The Chairperson:

Therefore, we are talking about next April.

Mr Donaghy:

We are talking about April 2011 to March 2015. It is a four-year period, which can make the situation more complex, because it is a long time. However, we will try to cover that as far as we can.

This is our first engagement with the Committee on the 2011-15 budget. I am delighted to be here to have this discussion with you. I am keen to have a productive discussion, talk to you and provide whatever further or better information that you think will help to build the necessary understanding for this important debate. As we have this debate, we believe that there is a special case for health and social care. That is not a straightforward issue. It carries significant implications for other public spending Departments in Northern Ireland, so we do not say that casually or lightly. It is important, however, to make that case and have that debate.

The Northern Ireland draft Budget is due on 20 October. That is when Whitehall will confirm how much money Northern Ireland will have. Until that point, we are making assumptions that are based on good information. Our colleagues in the Department of Finance and Personnel (DFP) are making assumptions and sharing them with us, and we are responding to them. The definitive Budget statement comes on 20 October, and Northern Ireland cannot formalise its intentions and have a conversation with the Northern Ireland public about what that might mean until after that date, hence the reference in our presentation to the consultation period after 20 October.

Our assumptions — we have no reason to believe that they will change when the final Budget

is known — are that Northern Ireland can expect no overall increase in the amount of funding; it will have exactly the same amount of cash or thereabouts in each of the four years from 2011 to 2015 that is has in 2010-11. That is unique for us, and we have never faced such a scenario. We always had a debate about how much beyond inflation we would receive. In this context, Northern Ireland would receive nothing for inflation. It would have the same amount of money in flat pound notes in 2011-12, 2012-13, 2013-14 and 2014-15 as it has this year, despite knowing that there will be pay and inflation pressures to meet and, in the case of health, significant other demographic and demand pressures.

In that context, DFP told all Departments to make provision for £1·47 billion of savings — 18% of the Northern Ireland total — and to use that as a war chest or a kitty to try to cope with the pressures that all Departments will face. DFP will support the Executive in making decisions about distributing that in due course. The DHSSPS contribution to that central kitty is £758 million.

The Chairperson:
Is that over four years or one year?

Mr Donaghy:
That is by year four. For simplicity's sake, I am saying "by year four". It is a different picture as we cast our way back to the present, but it becomes too complicated if we try to give you figures times four. That caveat of "by year four" should run through everything that I say.

The public expenditure survey analysis (PESA) is published each year by HM Treasury. It is regarded as the definitive statement of how each Administration is organising its spending on public services. The graph that we provided for members shows that, for most years, Northern Ireland was above average UK spending. In Northern Ireland, therefore, spending on health was above average relative UK spending as a whole. Scotland is well above the average, and we have always known that Scotland enjoyed a higher level of health funding than Northern Ireland. Wales also enjoyed a modestly higher level of health funding than Northern Ireland, while England, with which we are always compared in can-you-do-better debates, was at a lower level than the other three Administrations.

In July 2010, PESA published information that stated for the first time that Northern Ireland's

level of funding for health is below that of England. It is not only below the rest of the UK but below that of England. That is HM Treasury's view.

Our presentation shows a more precise quantification of that. In the index, 100 equals average UK spending. Therefore, the figure 104 is simply shorthand for 4% above the UK average, and 98 means 2% below that average. For many years, Northern Ireland was above the UK average. Based on the latest data that was published in July, Northern Ireland is two points below the UK average and one point below England. That is the situation before we even have a debate about whether there are greater health and social care needs in Northern Ireland. That is simply our relative funding. Do we spend as much as England? The answer, based on the Treasury's public expenditure survey analysis, is no.

I apologise for trotting through the presentation, and I am happy to return and explore any element in depth. With regard to the need context, there is a definitive statement about the relative need in Northern Ireland, relative to England in particular, because that is the comparison that Northern Ireland always faces. That definitive statement said that our need is 14% to 17% higher than England; it is 10% greater for health and 35% greater for personal social services.

That need takes account of the relative health and well-being status of people in Northern Ireland. A range of factors colour that need to give a view of how much more we need, such as the make-up of the population, unemployment levels, self-declared limiting long-term illness and housing standards. There is evidence of that in the higher levels of cancer incidence and coronary heart disease. There is much supporting data to help us to understand why Northern Ireland has a higher need.

Before we discuss that higher need, we are spending less per head of population than England based on the latest data. The definitive statement that Northern Ireland needs are 14% to 17% higher than England must be taken into account.

Bringing those two sets of data together gives a figure that members have heard many times, but I think that it bears restatement. For health, relative to England, taking need into account, we are around £436 million behind English levels of funding for a service of our size. For personal social services, the figure is about £200 million. The two combined amount to well over £600 million.

I will press on; if you want to pause me, Chairperson, or if members think that I have said something that they wish to challenge or better understand, I am happy to take interruptions. I will deal with health and social care cost increases. I now want to look ahead. We have established where we are and have come out of the period ending at March 2011. We can now imagine ourselves forward. It is clear that we are spending less per head on health than the rest of the UK and less than England. It is clear that we have higher levels of need, and we can quantify that. That means that our budget is some £636 million less than it would be if we were in England enjoying the average level of funding that applies there, weighted for our need — it is important to say weighted for our need.

What might we face as we go forward? I will seek to demonstrate that, as health and social care looks ahead, it has to anticipate higher pressures, which will lead to increased costs, than is the case for most services. Of course, I cannot speak for other services in Northern Ireland; my understanding is grounded in health, but health faces particular issues, and I hope to draw those out a little. My colleagues will be able to offer better examples when we get into a discussion following the presentation. By 2015, Northern Ireland will face some 23% higher costs for health and social care than we face now, all other things being equal, taking account of how our population will change and of what we have learned about how different health interventions can, and therefore should, be performed, such as coronary artery bypass grafts, prescribing interferon, or performing life-saving operations on macular degeneration. There is a whole range of such interventions, and colleagues will cover those much better than I can.

We looked to England to check that we were not over-egging the pudding or overstating our case, and we found that we were slightly below the average English health authority. However, overall planning assumptions and inflation — this is where we think that health is distinguished — sit at a little below 10% for the four years in question. DFP will undoubtedly take stock of that; it will hear from other Departments and may change that figure, but its planning premise is less than 10% compared with our view of more than 23% inflation. Why do we think it is over 23% inflation? I will try to break that down to allow debate on specific elements.

Northern Ireland has demographic growth; that is, our population is growing. The population is growing, and Northern Ireland has the fastest-growing elderly population in the UK — not the oldest population but the fastest-growing elderly population. Those two factors combined —

there are others, such as the increasing birth rate — mean that, like for like, to serve our population year to year as we have done to date, our demand for funds will go up by 1·3% per annum, because 1·3% more people will need the service, some of whom will be ageing and some very young. How does that look compared with other areas in the UK? We have been able to get information for two English health authorities: one expects an increased need of 0·9% and the second an increased need of 1·9%. It depends on the population; this is about Northern Ireland's population. There are detailed demographic models that build that information up. We calculated our own view of what unit price inflation will be and how our prices will go up year to year. We tried to compare that with others to ensure that we are not over-egging the pudding.

The next concept, residual demand, is probably the most difficult to understand, and I will talk about it in more detail later. We checked our view of how extra residual demand for services might manifest year on year, and we think it is in the range that we see elsewhere. Those are the components that we think drive much higher inflation for health than one would see for the generality of services. I am sure that colleagues will refer to one or two of those.

I have already explained demography. There are changes in disease profile, and we can do much more for people who suffer from cancer now because it is detected earlier. Heart disease is also detected earlier and treated better, and stroke care has improved. There are more people, and more is being done for those people. There will be other examples to come.

Alongside that, we need to improve access to care by, for example, reducing waiting times, and we need to increase overall expectations and demand. The next couple of pages of the presentation — I will not delay on them — provide some evidence of the extra activity, which is a manifestation of the extra demand and of improving access to care. That does not cover the changes in clinical practice, and my colleagues will comment on that in due course. However, members can see the scale of the additional activity that we face year on year as people, rightly, expect better access to services and better care.

The presentation gives some information on hospital care, domiciliary care and meals to clients' homes and provides other social care examples. There is a relentless push for health and social care to do more, and that must be taken into account as we plan for the future. The presentation shows that we have improved detection of cancer cases. We are helping people to survive longer, and mortality is decreasing. That is a fairly typical story in health and social care

in the Western World.

My colleague Sean Holland will talk about social care demand in a moment. Members are familiar with the Baby P case and the debates about Omagh. Every time a debate about quality of care and about what we can or should not do arises, there is, rightly, a pressure to respond. Therefore, based on our best experience, we have created projections of the future residual demand. We have given some examples of the areas in which that could manifest, and we will talk a bit more about them. Those projections drive the percentages that I spoke about earlier.

Overall, our expenditure will grow as a result of inflation, as is the case for all sectors. Furthermore, demand will increase expenditure, and we have tried to give the Committee a flavour of the origins of that demand. Finally, demography will lead to increased expenditure as our population grows and changes. We reckon that those increased spending forecasts will take our current spending from £4·3 billion to £5·4 billion, which is an increase of approximately £1·1 billion. That is the figure before we factor in ways to work more effectively and efficiently. We will, of course, continue to search for ways to do that.

Early indications — this is guesswork — suggest that our funding will be reduced by about £750 million to create a central pot for Northern Ireland. We could rely on the return of some £376 million to cope with inflation at the same rate as the rest of Northern Ireland. In that case, our overall funding will decrease by £0·4 billion. The key point is that we think that our spending will increase by approximately £1·1 billion, and we have tried to give the Committee a flavour of the unique factors, as well as the general ones, in health that drive that increase. From the information that the Department of Finance and Personnel has made available to us, our best assumption is that our funding level will decrease slightly.

A graph in the presentation shows possible scenarios based on the expenditure forecast and what will happen if our funding decreases. It also shows our spend for 2010-11. If our funding decreases over time in line with the assumptions that our colleagues in DFP have provided, health will have approximately £3·9 billion by 2015. The debate will continue on whether that is enough. That is by no means a final figure, but it is our first assumption as a planning premise and is based on information from our colleagues in DFP. We think that our expenditure will increase every year from now on because of factors such as inflation, growth in the population, the changing needs of the population and the residual demand as health and social care does

more. It can and should intervene effectively to improve people's life chances and their quality of life.

The presentation addresses the debate on protection for health and social care, and there is a strong case to do that. Indications are that health will be protected in England. That is not definitive; that decision will not be made until 20 October, which is the same time that Northern Ireland will learn of its Budget. Our best understanding is that it is highly likely that health will be protected from cuts, that its budget will not be reduced and that it will receive funding for inflation and a very small amount extra for growth. That is the outlook for health in the National Health Service (NHS) in the UK. The situation in Northern Ireland should parallel that. That will certainly be part of the Barnett read-across and part of what will inform Northern Ireland's settlement. We are part of national pay structures and, as I said at the start of the session, are already some £600 million behind England.

What is the scale of the potential cuts? Our expenditure could rise from £4·3 billion to £5·4 billion. The Department will work hard to avoid it rising to £5·4 million by doing things more effectively and efficiently. We have been working hard on efficiency for the past three years. However, if we continue to do things as we have been doing them, our understanding is that that rise will happen. We benchmarked those figures against England; we looked at the situation in Wales; and we are trying to get information from Scotland. As best as we can see, those are the types of assumptions that the Western World is making about changes in the need for spending on health. If there were no protection — that debate is by no means over, and a long discussion is to be had — the DHSSPS would need to reduce that planned expenditure by some £1·5 billion.

The following examples illustrate where we spend our money. They are not suggestions of what we might do to achieve a reduction in running costs. It costs about £1·6 billion per annum to run hospitals; we need £0·9 billion to run social care services; and the Fire and Rescue Service costs £0·08 billion, or £80 million.

Are savings achievable? Should we do better? Can we go further? The Executive commissioned DFP's performance and efficiency delivery unit (PEDU) to review the potential for cost savings in health and social care and in education — the two biggest budget-holding Departments. Minister McGimpsey has just written to Minister Wilson to agree the approach to that review. PEDU will be tasked with deciding whether the Department has done all that it can

or whether it can do more to reduce its future running costs. The timetable is yet to be agreed, but our understanding is that PEDU might report in October.

I am conscious of the time, Chairperson, but I will conclude quickly. With respect to capital investment in the health and social care sector, the key point is that the 10-year plan that existed in 2008 was based on an overall assessment of the need for investment in all public services across the infrastructure. The pattern of investment in health, as it happened within that 10-year plan, was low in health for the first three years. It was due to rise thereafter. It would not have been inappropriate to give every service the same rate all the time because certain projects have higher priority. Our concern is that we now have a debate about a much-reduced capital expenditure budget and that the 22% share that we need might be diminished. One graph in the presentation shows how the Northern Ireland capital departmental expenditure limit was expected to run from 2008 to 2015. Health had a low share in the first three years. We were concerned about that, but we made plans to make significant levels of investment from 2011-12 onwards. Now we are faced with the prospect of much-reduced capital funding. We want to ensure that equity prevails. People should not forget that we had low levels of funding in the past three years, and, on the foot of that, we need equal treatment and better access to the funds in the coming three to four years. Bernie Stuart can answer questions about the need for capital investment. Funding levels are specific to capital.

The key question is: what health and social care service is Northern Ireland prepared to accept? Without protection and inflation funding such as the English NHS has, Northern Ireland will have a very different service to the rest of the UK. It starts with a relatively lower level of funding, which would be exacerbated heavily if we have a different type of settlement for the period 2011-15. Furthermore, even with protection for inflation, we still face enormous challenges because there are unique Health Service pressures with which we have to cope. We acknowledge that it is difficult for Northern Ireland plc to pay for all that. However, unless we at least have funding for inflation for health and social care, we will not be able to sustain a Health Service such as is available in the rest of the UK.

Thank you, and I am sorry that that has taken so long.

The Chairperson:

We will have half an hour for questions. As I said, we will return to the issue many times

between now and Christmas. I have a couple of technical questions to set the scene. Do you expect that, under the next comprehensive spending review, there will still, on top of all this, be the usual 3% efficiency savings? Are you including that in what you expect to be reduced from your budget?

Mr Donaghy:

In the first instance, we have not factored in any efficiency savings. We fully acknowledge that the DHSSPS, like every Department, will deliver efficiency savings, and it is those efficiency savings that begin to tack back from the £5·4 billion total spending. However, given our experience over the past three years, we know what a challenge further efficiency savings will present to us. Nevertheless, we are happy to engage in the debate about what savings can be achieved, and we will do that through PEDU. We are happy to begin to make proposals when we know the budget against which we are working, and we have some sense of scale against which to make our plans.

The Chairperson:

Has there been an indication from the Treasury that the Department will not be subject to 3% efficiency savings, or has that simply not been built into the assumptions?

Mr Donaghy:

My understanding is that it has not been built into the assumptions. The scale of what we face in Northern Ireland — 18% to 19% cuts in expenditure — is such that the phrase "efficiency savings" has not been seen as the way to avoid reductions in public spending that may impact on front-line services. Efficiencies will be required. We will set out what we can do, and PEDU will check it. We know that we have already gone down the review of public administration (RPA) route, and we know that we achieved a great deal over the past three years. Efficiencies will be part of the debate about the future, but they will not be the solution as to how we cope with the level of the funding reduction that we face.

The Chairperson:

I know that this is not of much solace to you, but are you building in the assumption that you still retain the first £20 million of monitoring round money per annum?

Mr Donaghy:

We are making a bid to that effect. We are required to bid from scratch, and we will bid for the formal restitution of that £20 million. All bets are off from April 2011. We are required to restate what is required, which will include the £20 million.

The Chairperson:

How are you comparing like with like when the comparisons are with England, Scotland and Wales, which have different systems? We are the only unitary health and social care system. Indeed, we also have the Fire and Rescue Service, which is very unusual because that is a local authority function. Can you disaggregate the numbers sufficiently to be absolutely clear that like is being compared with like?

Mr Donaghy:

HM Treasury undertakes that function. It also undertakes an analysis that distinguishes between health and social care. It is possible to do that. There is some entanglement in Northern Ireland but not so much as to make those figures invalid. We can define our health system pretty clearly here and, along with every other spending Department across the UK, we make returns to HM Treasury about what we spend our money on. The Treasury factors in that information to arrive at comparative plans on spending, area by area and region by region. One can go through its plans and pluck out not only Northern Ireland but areas across the UK.

The Chairperson:

Nevertheless, some savings must come to Northern Ireland because of that unitary system.

Mr Donaghy:

We believe that there is significant benefit in that. Many observers come to Northern Ireland to learn more about the benefits of an integrated service. We are debating how much money we have in total. Integration has helped us to get by with what we have been given, but when we examine what we have been given, the total, irrespective of how well we have been able to use it, is less per head than in England. It is important to note that, for the first time, we dipped below the UK and the English average in July 2010.

The Chairperson:

For clarification: are you content that George Osborne said that he is ring-fencing health as

opposed to ring-fencing hospitals?

Mr Donaghy:

He has made the distinction between health and social care. The NHS does not provide social care: the NHS in England, more widely — this distinguishes it from Northern Ireland — provides hospital care, community healthcare, mental healthcare and some learning disability care. The majority of services for older people, some learning disability care and some other elements of care that we call social care — Sean Holland can amplify on that — are managed and delivered by local authorities. When the Treasury talks about budget management, it simply has not debated whether social care should be protected. It has simply said that it is content that it will protect health. From our perspective, we could not conscience protecting health and not protecting social care. It is an integrated service. We know that we are even worse off, relatively speaking, in social care than we are in health.

The Chairperson:

Let us say that the political argument is won and that we receive the same level of ring-fencing as GB, which, from what you say, is what you pitched for. What would be the implications for the rest of the Northern Ireland Budget? I followed all your arguments to that point, but I have not got my head round that. What would it cost the Department of Finance and Personnel in Northern Ireland to ring-fence the services here to the same extent as GB?

Mr Donaghy:

We have only estimates for that. We need colleagues in DFP to provide the definitive information on that. It depends on where we start from. If we start from the Department's figure of £3·9 million, and if we read DFP's assumptions and understand them properly —

The Chairperson:

Did you mean to say "£3·9 billion"?

Mr Donaghy:

Yes, I did. Excuse me. Did I say "£3·9 million"? If we compare that with what the budget would be if it were protected, we would need about another £800 million.

The Chairperson:

Is that over a four-year period?

Mr Donaghy:

Yes, it is. I will compare that with the current funding, which is £4·3 billion. If that were protected from cuts, we would continue to have £4·3 billion. In England, the health budget is protected from cuts, and if the same were to happen here, the budget of £4·3 billion would be sustained. If the Department were then funded for inflation on top of that, its overall spending would go up to some £4·5 billion. We think that that figure should be higher — £4·7 billion — to include protection for social care.

The Chairperson:

If the Department were successful in winning the political argument, which is a logical one, about receiving exactly the same protection for its budget as its counterpart in GB, you said that it would have to find £800 million over a four-year period to do that on a like-for-like basis. However, obviously, the full budget of £4·3 billion would not be protected under that because there are elements of the health budget in GB that are not protected.

Mr Donaghy:

Members will have these figures: the budget for health in Northern Ireland accounts for £3·3 billion of the £4·3 billion. Social care has a budget of just over £900 million, and the budget for the Fire and Rescue Service largely makes up the balance of that.

The Chairperson:

Therefore, is the £800 million based on the lower figure or the entire budget of £4·3 billion?

Mr Donaghy:

I have not written these figures down to present to the Committee, and I do not want to get to the stage where I am confusing members. If the Department budget were to end up with the same level of protection for its budget as its counterpart in England, it would have a budget of some £4·7 billion. Its current budget is £4·3 billion. That is the cleanest and simplest way to state it.

The Chairperson:

You are aware of the enormous impact that any level of ring-fencing for the health budget in

Northern Ireland would have on the rest of the Departments' budgets. Unusually, the budget for health here has a much bigger slice, proportionately, of the overall cake than the corresponding one in GB, where there are also budgets for defence, foreign affairs, and so on.

Mr Donaghy:

It is very important that I emphasise this point: part of the data that was published in July 2010, taking account of all relevant expenditure, suggests that expenditure on health in Northern Ireland is relatively lower than in the rest of the UK.

The Chairperson:

I accept that argument, but the problem is that the health budget has a 40% slice of the cake in Northern Ireland, because there are fewer Departments here than in GB. Therefore, the knock-on impact on roads, social housing and agriculture is bound to be much higher here than it is in GB, because, in Northern Ireland, the health budget has, by far and away, the biggest slice of the cake. As that argument rolls out, the Committee or individual members will want to know what the implications will be for everybody else if we fight to have the budget ring-fenced.

Mr Donaghy:

First and foremost, it is for colleagues in DFP to provide that information. We will do our best to ensure that the Committee is well informed about that. However, I do not have a clear line of sight on the budgets for all other Northern Ireland Departments. However, I can say definitively that we are no different from the Administrations in Scotland and Wales in how we cope with our budgets. Although the English Administration has a budget for defence, they will have achieved savings from that on behalf of the UK as a whole. Thereafter, everyone faces exactly the same tableau. The English Administration will have set aside the budget for defence, which is required for something specific, and looked at how it is fixed with the rest of its Departments and how they will have to bear their share. I do not think that it is any more difficult for us to protect the health budget in Northern Ireland. It is not easy to do that anywhere, but our disposition does not make it any more difficult for us to conceive of that than it is for those in England, Scotland and Wales.

The Chairperson:

I am going to ask you a very unfair question, because I am sure that everybody will want to know the answer. Let us assume the worst-case situation that, in fact, there is no ring-fencing and that

every Department in Northern Ireland takes an equal and proportionate hit as a result of the cuts. Has the Department considered what would happen? If it were faced with that unpalatable situation, what sorts of actions does it envisage having to take to meet those savings? What concrete changes would it have to make to the provision of health and social care in Northern Ireland?

Mr Donaghy:

We are undertaking work to understand how we would cope with a reduced budget. It would not be appropriate to air what would be effectively scare stories when we do not know what our budget will be. I mentioned earlier that the Minister had agreed with the Assembly's proposal to conduct a review of the opportunity for cost savings in health and social care under the auspices of PEDU. As recently as today, Minister McGimpsey wrote back to Minister Wilson about how we propose to proceed with that exercise. That will give us an independent view, as well as a health and social care view, of what cost savings are realistically achievable. For me to start a debate that it might be this or it might be that would simply make the public more frightened than needs to be the case. We need to wait to see what our budget will be and set out a savings plan that matches our budget bill.

Mr Gallagher:

Will we have the PEDU report by the time of the budget announcement?

Mr Donaghy:

The PEDU report will be a joint piece of work between the DHSSPS and DFP. It will be a challenge to complete it by that time, but there is no reason why we should not have it by then. It would certainly be helpful and advantageous to have it by then.

Mrs O'Neill:

Will you explain more about how PEDU will work? What is the interaction? Does PEDU conduct a desktop exercise? How is it carried out?

Mr Donaghy:

That is what is under discussion between DHSSPS and DFP. Ministers Wilson and McGimpsey will have their first bilateral engagement on 13 September, and that will be on the agenda at that discussion. The proposal is that work that has been, and is being, undertaken by health and social

care will be reviewed by PEDU to ensure that we are not doing the same thing twice. We need to work out the details of that, and both Ministers need to be content that it represents a robust approach to the exercise.

Mrs O'Neill:

Further to Tommy's point, given that there are recognised inefficiencies in the Department of Health, Social Services and Public Safety, it is important that we get that report before budgets are finalised. Having the report before then is an important part of the jigsaw in progressing the ring-fencing argument. I know that that is beyond your control, but it is vital if we are to progress that argument any further.

Mr Donaghy:

It is certainly important that the best possible information is available before budgets are finalised.

The Chairperson:

I will continue that line of thought. The Department of Culture, Arts and Leisure (DCAL) and the Office of the First Minister and deputy First Minister (OFMDFM) have already been very honest with their respective Committees. They outlined what can be expected if they have to take the full hit. DCAL indicated that a reduction in funding will lead to at least 100 redundancies in the arts sector. Yesterday, OFMDFM said that it has to deliver £35 million in savings, although I know that it has a tiny budget compared with yours.

Some may argue that there is a strong case for elements of ring-fencing. How can you make those arguments if the Department is not prepared to tell us the implications of taking the full hit? I know that there is a concern about scaring people and that you may outline a scenario that will never happen. However, if there is to be an argument that health needs to be protected from some of the cuts, as there has been in GB, we need to know, to some extent, what will happen if it is not protected. People will hardly be too exercised by an announcement that administrators will be laid off, bonuses will be cut back and travel budgets will be reduced if the health budget is not protected. However, if the cuts relate to more fundamental services, people may have a different view on ring-fencing and protection.

Mr Donaghy:

I take that point, Chairperson. Bear in mind that a review of public administration was completed in health. It meant 1,700 job cuts, 1,300 of which have been realised to date, and a reduction in the number of trusts from 18 to six. That released, with huge associated challenges, £53 million. The order of challenge that we are talking about now is between £1 billion and £1·5 billion. No amount of more cost-effective organisation of how taxis are procured or how many managers we have will get us to that level. It requires fundamental change in health and social care.

It would be irresponsible for us to begin to describe that without engaging the population of Northern Ireland properly and without knowing what the challenge is. However, our presentation has given you a flavour of where we spend our money. We are very happy to make more of that information available to the Committee. We are not saying that we will find our savings in those areas. However, we have to find savings from areas in which we spend money; if we spend £4·3 billion, that is where the savings will have to be found.

The Chairperson:

DCAL has been able to say that it will find the savings and that there will be 100 fewer jobs in the arts sector; it has been specific. If you are saying that you can find savings in ways that do not affect front-line care, the argument for ring-fencing the budget becomes more difficult.

Mr Donaghy:

We are not saying that. Finding savings of that order will affect front-line care. Our plea is that we need a clearer steer on the scale of the challenges so that we can take the necessary actions.

The Chairperson:

You must have a set of tables that outline what is likely to happen if you receive a certain level of budget so that, come 20 October, you will be able to say what impact the amount of money that you have been given will have on services. Will we be told where the savings will be made at that stage?

Mr Donaghy:

We have had a discussion about the PEDU report, which is a good, independent, quality-assured vehicle to say what is doable in health and social care and how to manage resources. That will give us definitive information on the type of savings plan that is achievable for health and social

care and what it might mean to deliver it. It is difficult to get your head around such scales of expenditure reduction; there will be no increase in the Budget in Northern Ireland above inflation, yet we are asking for more money for health. If that request were granted, there would be implications elsewhere.

That is a hugely important discussion. It is not like the debates that we have had over the past three years; it is of a different order. We would wish to have some scaling on that before we embark on saying where savings could be made. It would not be appropriate to say anything before that. We hope that better information will be available soon, and we are happy to continue to talk to the Committee. However, at this stage, it does not feel appropriate to hypothesise about the scale of budget cuts and say what will have to be closed or done differently.

Dr Michael McBride (Department of Health, Social Services and Public Safety): There are differences between provision for health and that for other public sector services in that health is very much demand-led. Much of that demand is not readily within our control. Sean Donaghy mentioned changes in demographics and the population. Northern Ireland is experiencing the greatest increase in the rate of ageing of any part of the UK. Up to 2020, we will have the largest increase in the population over the age of 65 and in the population over the age of 85.

What does that mean? As we know, the health costs associated with the provision of health and social care increase significantly for people who are over the age of 55, and rates of all long-term conditions increase over time. Therefore, there will be significant pressures because of our ageing population. That is not within our control.

There are a range of other demand issues. There are trends and challenges that we discussed in Committee due to smoking, alcohol and obesity. We have a public health strategy to address those issues. We discussed the Committee's report into obesity and the Northern Ireland Audit Office report that examined obesity and its impact on the incidence of diabetes. Some 60,000 people in Northern Ireland have diabetes, and that figure is projected to rise to 85,000 by 2015. Treating people with diabetes and its complications puts severe demands on the Health Service.

The 2008 Audit Office report examined the performance of health and social care in Northern Ireland and highlighted improvements in survival rates for all the major cancers. However, with

an ageing population and the consequences of poor diets, a lack of exercise and a misuse of alcohol, there will be an increase in the incidence of cancer.

Cancer treatment is changing. There is an improved rate of survival, improved approaches, early detection, diagnostic tests and new drugs. In the past three years, we invested £33 million in new drugs to treat cancer and rheumatoid arthritis. We estimate that there will be real cost pressures to ensure that people in Northern Ireland have the same access to potentially life-saving or sight-saving drugs. Previously, we talked in Committee about Lucentis, which is a drug that is used to treat macular degeneration. In the past three years, we invested £8 million to make that treatment available to people in Northern Ireland. It prevents people losing their sight, maintains their mobility and allows them to remain in employment. We have a range of new drugs and new pressures that will not go away. That is why the demand and costs that are associated with the provision of a health and social care service that is comparable with the rest of the UK is so important. There are a range of other examples to which Sean Holland will refer.

Mr Sean Holland (Department of Health, Social Services and Public Safety):
In the world of social care, there are issues that drive demand. We have an increasingly complex society in respect of ethnic make-up, which makes the delivery of health and social care more complex. There are new technologies with which to contend. For example, in child protection, 10 years ago, the Internet did not feature as a significant threat to the well-being of children. It most certainly does now. That is an additional demand.

There are changes in family structure. Issues such as higher levels of mental health need in Northern Ireland and the growing use of illicit drugs all drive demand. In addition, as was the case with the healthcare examples that Michael illustrated, we have similar examples in social care. The Committee has been very concerned about the McElhill case and the subsequent inquiry. That inquiry made many recommendations, which have been implemented. That is not free; that drives up the cost and the need for services. In turn, that also uncovers further demand. For example, one of the main recommendations from the McElhill case was that social services and the Police Service of Northern Ireland (PSNI) should improve co-operation. We invested heavily in that co-operation, appointing new posts of social workers who work alongside police officers. The result is that we now identify more children and young people who are in need of protection and safeguarding than we were aware of previously. Over the past five years, there has been a 48% increase in the number of child protection investigations, a 75% increase in the

number of initial child protection case conferences and a 32% increase in the number of children who are referred to social services. As we get better at doing our job, we uncover more demand.

It is worth bearing in mind that those are truly demand-led services because we have statutory duties to respond. We cannot say that we will provide only a certain level of service because we have only a certain amount of money. Under article 66 of the Children (Northern Ireland) Order 1995, if we believe that we need to investigate the well-being of a child, we cannot say that we do not have enough money. It is an absolute duty; we must do it. With the greatest respect to the pressures that may be on other parts of the public sector, they do not have the same issues that drive the level of demand in health and social care.

Mr Martin Bradley (Department of Health, Social Services and Public Safety):
Chairman, I am conscious of your challenge to Mr Donaghy about being able to describe what may happen in the future. Dr McBride and Mr Holland tried to do that. Listening to that analysis, it seems to me that if it all came to pass, we are potentially facing up to a quarter of our budget for health and social care in Northern Ireland being lost. That is an eye-watering amount of cutback in our services. It would be extremely difficult to see that through in the time period that would be available to us during that spending period. As Chief Nursing Officer, I believe that it would raise major issues about public health and safety. It would also raise major issues about our ability to be able to do that in a timely and co-ordinated way and our capacity to meet that challenge. It would definitely break parity with the rest of the United Kingdom, and we would have a completely different health and social care service in Northern Ireland. That is one of the bottom lines that we face.

The Chairperson:
Quite a few members want to ask questions. I have not forgotten about the Deputy Chairperson — I will let you back in — but quite a few members have been waiting for a long time.

Mr Easton:
I am trying to get my head round some of the figures. If I tell you what I think, will you tell me whether I am right so that I know what I am talking about. Is it correct that £758 million is to go towards a war chest?

Mr Donaghy:

That is correct. That comes out of health's budget. Those are initial figures from DFP. This is a Budget planning process, and, undoubtedly, some figures will change. However, those are the assumptions that were shared with the Executive and the Departments.

Mr Easton:

In addition, because of inflation, planning, population change and demands, you need an additional £1·5 billion. Is that right?

Mr Donaghy:

If we accept that we will lose that money — although we say that we should be protected, as the English NHS is — and that, in addition, there will be significant inflation, some of which we described, there would be a gap of around £1·5 billion.

Mr Easton:

You said that you hope to get £250 million to £300 million back from the £758 million fund.

Mr Donaghy:

It is early days. However, working on assumptions, we arrived at that figure.

Mr Easton:

Have you been guaranteed that sum?

Mr Donaghy:

No, we have not. There will be no guarantees until we know the Budget and until the Executive have had an opportunity to debate it properly.

Mr Easton:

Does the £1·5 billion that you need extend over a four-year period?

Mr Donaghy:

Yes, it does.

Mr Easton:

That is clearer now.

Mrs Mary Bradley:

Mr Donaghy, in your demand for social care, you mentioned a 62% increase in domiciliary care and care packages. Is that for the whole of Northern Ireland?

Mr Donaghy:

If you do not mind, Mary, I will hand you over to Sean Holland, who can speak much more knowledgeably about that.

Mr Holland:

My understanding is that it is.

Mrs Mary Bradley:

That surprises me. Obviously, you do not include the people who have applied for packages but who were unable to obtain them.

Mr Donaghy:

No, we do not. This is about the delivery of care —

Mrs Mary Bradley:

You are including only what you deliver and are not taking account of what you still need to deliver.

Mr Holland:

Your point is valid. It is about thresholds moving up. We have already seen thresholds move up in domiciliary care. If we are faced with the type of situation that is being described, we all know what would happen to thresholds.

Mrs Mary Bradley:

If we all spoke about the areas that we represent, we would hear about the high need for that type of service, which people cannot obtain. There are waiting lists. That is not included in your figures, which cover only those who are being provided with the service.

Mr Donaghy:

Yes.

Mr Holland:

The demographic pressures that Sean and Michael referred to are particularly significant for domiciliary care. With a growing older population, and, in particular, within that, a growing population of what is sometimes called the "old" old, the pressure for domiciliary care becomes truly acute. Therefore, as that demand manifests, the type of service that, historically, may have been provided and which was very valuable in enhancing the quality of people's lives, perhaps enabling them to stay in their own homes, becomes much less tenable.

Mrs Mary Bradley:

It also makes the situation awkward for hospitals. I know of one case in which doctors told a gentleman that he was fit enough to be taken home and cared for. However, he could not come home and had to stay in hospital for 16 weeks.

Mr Holland:

That point is relevant to the debate on protection for health rather than for social care. In England, the decision is about protecting health, and my colleagues there who work in the arena of social care are involved in many discussions with their health colleagues about future difficulties. If social care faces the anticipated rise in demand, and if it is not protected, that will undermine some of the protection for the healthcare sector, as people will be admitted to the acute sector because of the absence of a social care package that could maintain them in the community. Beds will be blocked in the acute sector because of the absence of, or the waiting time for, a social care package to enable someone to be discharged from the acute sector.

Dr McBride:

Apart from that not being good for people — people want to be cared for and have the right support in their own homes — as Sean Holland quite rightly pointed out, inappropriate admissions, when people could be supported at home, impact on the efficiency of the acute sector.

There is another issue about the ageing population. We spoke about Northern Ireland having

the greatest number of people over the ages of 65 and 85 anywhere in the UK by 2020. However, that is already a problem. In Northern Ireland, the population over the age of 60 increased by 4·2% between 2006 and 2009. In the same period, the population over the age of 85 increased by 6·4%. Therefore, that is a current pressure. I support Sean Holland entirely in what he said about the artificial separation between health and social care and in what he and the Chairperson said about the real benefits of an integrated health and social care system, which other parts of the UK currently look to Northern Ireland for.

Mr Gallagher:

As the demographics show, it is clear that pressures are rising in accident and emergency departments in hospitals and on domiciliary care. However, for some years, we have been led to believe that a more integrated service, including local commissioning groups, would do two things: ease the pressure on hospitals and reduce costs. Has the Department decided whether those local commissioning groups will do the work that they are intended to do, or will they simply languish, as they appear to be doing at the moment, and not making any appreciable difference by having a beneficial effect or by saving the Department money?

Mr Donaghy:

There are two questions there. First, there is a huge amount of evidence — I will be happy to assemble it — to show how the shifts from hospital-based care to community-based care have already been happening. That is part and parcel of how our service has managed to get by in the context of increasing demand.

Mr Gallagher:

I cannot see that in the picture that is being presented to us. The pressure on secondary care is still rising, and the Health Service is costing more and more. What difference is being made by those shifts in the delivery of care?

Mr Donaghy:

I do not have data to hand, and I am reluctant to make it up or use my hazy recollection of the figures. However, you will see that we are delivering more care in hospitals with a smaller number of hospital beds. That is what we mean by working more effectively and working better over time. We must bear in mind that we are still £600 million adrift of the rest of the UK, based on our need. Some of the pressures and symptoms are a reflection of the fact that, as of now,

based on need, we are £600 million less well funded than England, in particular.

Mr Martin Bradley:

Mr Gallagher is right. There is increased activity in the system, but we must not forget that the population — in particular, the elderly population — is increasing. There will be more use of the system. However, there has been an increase in turnover in the hospitals sector. There is a drop in the length of time that people are spending in hospital, more procedures are being done on a day-case basis, and more people are being seen as outpatients. That activity is still there; if we were not doing that, the figures would be much worse than they are at present. Inevitably, as a society begins to get older — not just in Northern Ireland but across the Western World —more demands will be made on the service. That is in the nature of the situation.

As Dr McBride said, we are doing more for people. More people are surviving who would otherwise have died of chronic conditions. We have more children with gross disabilities who are living longer lives. All that is part of a civilised society; it is what we have to cope with. We try to make efficiencies and deliver services in better ways because, otherwise, we would have been broke long ago. However, we have not made those efficiencies to such an extent that we can lose one quarter of our budget.

Mr Gardiner:

I am not playing politics here. This issue is too serious. These professionals come to Committee meetings, and they have done so again, to tell us of their fears that, because of cuts in services, they will not be able to provide for our kith and kin. I am not going to be Pontius Pilate and wash my hands and walk away from that. We must face reality.

I am prepared to move a motion that this Committee should go forward with ring-fencing the health budget. I question whether I will get a seconder for my proposal, but I am prepared to postpone it if the Department has to come back and give us more figures and evidence that outline how much is being cut and the severity of the losses of life that we are likely to have to put up with.

I hope that every one of us can take it on our conscience that we are dealing with human beings and that we should be protecting the Health Service. That is our job; we want the best for the people of Northern Ireland. We do not want to be a Third World country, running behind

England, Scotland, Wales or any other country or part of the United Kingdom. We want to be the best.

The Chairperson:

I did not detect a question; the member may wish to submit his concerns as a proposal to be discussed at the next meeting.

Mr Gardiner:

I propose now that we consider seriously —

The Chairperson:

You cannot do that. Procedurally, you must put the proposal on the agenda so that all members would know that the subject was to be discussed at the next meeting. I am more than happy to allow such a discussion to take place. I was trying to tease out the exact implications of ring-fencing because I accept that that will be a big debate.

Mr Gardiner:

It will have to come. We cannot go on like this at every other meeting; it is not good enough, because people in the Health Service are struggling.

Mrs O'Neill:

On that point, surely today is just the start of a process of engagement with departmental officials —

Mr Gardiner:

That is why I said that they would be coming back with more information. However, how long will it be before the officials finalise the information and bring it to the Committee? Will it be another week or fortnight? There is not much point in my putting down an agenda item for next week's meeting if the witnesses will not be here and members are not fully in the picture about savings. There are members here who genuinely want to help and to contribute to saving our Health Service and to ensure that we get the best from it.

Mr Donaghy:

I take that point. It is clear that the Executive will not be in a position to make a decision until

they know what their Budget is on 20 October. We do not know whether there will be Budget debates at the Executive before then. Our Minister will engage with Finance Minister Wilson on Monday, but I will take on board the Committee's points regarding the need and thirst for more information and a better understanding of the implications. We will do our best to provide indicative timelines that help us to plan further discussions, but it depends on how quickly such matters move through the Executive and, particularly from the Department's perspective, how quickly the PEDU report moves along.

The Chairperson:

Will the PEDU report coincide with 20 October? Will we have that report before the Budget announcement?

Mr Donaghy:

There is every possibility that we may have it; however, the timetable is not set and agreed. I must re-emphasise that the Minister has not yet had a bilateral meeting with Minister Wilson. That meeting will take place on Monday.

The Chairperson:

I would love to be a fly on the wall at that meeting.

Mr Buchanan:

Do the witnesses believe that efficiencies can be made in any other areas in the Department of Health, Social Services and Public Safety, or do they think that all possible efficiencies have been realised? What percentage of the health budget goes towards capital build? Over the next four years, will the severity of the cuts that the officials presented to the Committee today have such an effect that all capital works will be put on hold so that all money previously earmarked for such works will be directed towards service delivery rather than newbuild?

Dr Bernie Stuart (Department of Health, Social Services and Public Safety):

The capital process is being taken forward separately. The Executive are doing that on a zero-based process, so it all goes back to scratch; all demands go into the system. Committed contracts will go forward first, followed by an assessment of need. It is forecast that the ISNI II allocation, on which our planning as based, is now more or less dead. Based on best estimates, DFP indicates that we will be looking at approximately 30% less over each of the next four years.

In this case, it is not by the end of the four years, so we will have 30% less than we would have had in total.

From our perspective, we had expected to receive £1·3 billion. Even if we were to get the share that Sean Donaghy indicated we wanted — 22% — we would anticipate getting somewhere in the region of £800 million to £900 million. The Department has a baseline of approximately £100 million a year for fixed costs to replace general capital, replace medical equipment that fails, ICT systems, pandemic flu costs, and so on. Therefore, if we were to receive the anticipated amount, we would be looking at only £400 million in total for all works, including risk management.

It should be emphasised that the health estate is the biggest public sector estate and probably the oldest. Many of our buildings are 40 or 50 years old. Some mental health buildings are 100 years old. Therefore, as we fail to replace existing buildings, we will have a greater need for maintenance. In effect, we throw good money after bad by maintaining buildings because we cannot afford to replace them. The changes in service that Dr Michael McBride and Sean Donaghy talked about require a modern infrastructure; therefore, by not replacing them, we are building in inefficiency. In the first instance, therefore, we need a sufficient level of funding to keep the service going and then to be able to bring about the necessary modernisation to be able to deliver a modern Health Service.

Mr Donaghy:

To complete the answer to some of the questions asked: can health and social care be more efficient? Of course we can, and we will never rest on our laurels in the pursuit of efficiency. There is always a place to look for more efficiencies. However, having achieved 9% efficiency savings over the past three years, the Department knows the scale of the challenge, what a hard grind that was and how tough it was for staff who, all the while, are improving their productivity. Whether the Department could achieve a further 9% again in the period ahead is in question. If it were simply a question of efficiency, of working harder and cleverer and being smarter that would be a real challenge, but the Department has to consider making a 25% cut in its potential healthcare budget expenditure. The Department will be more efficient, will never stop seeking more efficient and effective ways to operate and staff are always keen to improve. The best care is often the most cost-effective care, but that would not bridge the gap that we are talking about.

Dr McBride:

The discussions are still at an early stage, but I want to discuss the projected figures outlined today. I am a doctor and not a director of finance or a politician. As a doctor, I can see no way by which we can safely remove, as Martin had said, one quarter of our potential budget need and continue to provide a safe and dignified form of high-quality care to the people of Northern Ireland, which, most importantly, is at a comparable level with the rest of the UK.

Mrs O'Neill:

I wish to clarify something. DFP has set out its programme of assumptions. Were all Departments due to report back to DFP on that tomorrow?

Mr Donaghy:

There were key points in the timeline, which was set out by DFP in an attempt to bring all the information together in as timely a way as possible. The Department has co-operated with DFP to the fullest extent and has made information available to its colleagues in DFP as it has received it. Pending the Minister's discussions with Minister Wilson, neither he nor the Department have taken an official line. As soon as that happens, the Department will be able to cement that down and make those formal and final returns to DFP.

Mrs O'Neill:

Will the Department share that information with the Committee?

Mr Donaghy:

The Department will, of course, share that information in due course.

The Chairperson:

The Committee will return to this subject many times between now and Christmas, and I thank the Department for fielding such an expert team today. The issue will dominate the debate in health. Indeed, at the start of this week, the press asked me what were the three main issues for health in the coming year, and I replied: budgets, budgets and budgets, because that is the reality.

As we move forward, the Committee would appreciate being kept up to date. There will be a major argument in the Assembly about how we apportion what clearly will be quite some pain. There will also be all sorts of arguments about which areas should take that pain and what

proportion each area should take.

Committee members seem happy enough with today's discussion. I think that Dr Holland will remain with the Committee for the next evidence session.

Mr Holland:

Yes; I will stay.

The Chairperson:

I suspect that the Committee will see the other witnesses quite a few times over the next few months.