Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Draft Budget 2011-15: Evidence Session with the Minister of Health, Social Services and Public Safety and Departmental Officials

13 January 2011

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Mickey Brady
Mr Pól Callaghan
Mr Alex Easton
Mr Sam Gardiner
Mr Tommy Gallagher
Mr Paul Girvan
Mr John McCallister
Ms Sue Ramsey

Witnesses:

Mr Michael McGimpsey	)	Minister of Health, Social Services and Public Safety
Ms Catherine Daly	)	Department of Health, Social Services and Public Safety
Dr Andrew McCormick	)	
Mr John Compton	)	Health and Social Care Board

The Chairperson (Mr Wells):

I welcome the Minister of Health, Social Services and Public Safety. Your team is well known to us: Mr John Compton was here earlier to discuss swine flu; Dr Andrew McCormick is the permanent secretary to the Department; and Ms Catherine Daly is acting under-secretary for the

Department's resources and performance management group. As usual, I ask the Minister to make a presentation, after which I will invite members to ask questions. We have an hour and five minutes to cover what is an extremely important subject.

The Minister of Health, Social Services and Public Safety (Mr McGimpsey):
I am grateful for the opportunity to brief the Committee on the implications of the draft Budget proposals. We are currently in the consultation phase, so I hope that the draft Budget is not a done deal. It is important that the Committee is clear about the implications of the proposed allocation and what it means for the population. Today, I published a consultation document on the Department's website, which outlines the implications of the draft Budget's proposals for the Department. I have also provided a written briefing to the Committee, which, I hope, will assist members.

As part of the normal process, a commissioning direction will be issued to the Health and Social Care Board, which will bring forward a detailed commissioning plan for April 2011.

I remind members that it was originally anticipated that the Budget would be brought forward last September. However, the draft Budget was concluded by the Finance Minister only in the second week of December. That delay has created additional pressures in the service.

The draft Budget proposals mean that, by the end of the Budget period, the entire health and social care budget will have been cut, in real terms, by more than 2%. That is a cut against the existing budget, not a cut against what is needed. In short, that means that the Health Service does not have the funding to stand still, never mind meet increasing demands.

It has been suggested that the health budget has been protected, but that is not the case, and any such claim is bogus. I will put the health budget in context: £5·4 billion is needed to meet the expected demand by 2015, which is year four. The draft Budget offers £4·6 billion, which is a shortfall of £800 million.

It is not just about the scale of the savings that are required; it is about the profile of those savings. Currently, year one is the most difficult year. That means that, in less than 10 weeks from now, the service will be £200 million short. That could mean that we will be compelled to examine areas in which cash can be released quickly: restricted access to domiciliary care, bed

closures, longer waiting lists, a freeze in new staff recruitment, restriction on the availability of new drugs for patients, reductions in funds to the voluntary sector, possible job losses, changes to co-payments and no funding to run new buildings. That is because we have to find the money instantly. We have no opportunity to plan. That is for year one.

I am being given stark warnings from chief professionals across the service, and these are the facts. The pressures that we have include paying for the growing and aging population, paying for new drugs and treatments, keeping waiting times short, implementing National Institute for Health and Clinical Excellence (NICE) guidelines in line with the rest of the UK, and resettlement of those with learning disabilities and mental-health patients.

It is a matter of determining what we consider to be the priority. It is clear that the public in Northern Ireland consider health to be their priority. I ask for the Committee's support. I cannot stress enough how dire the situation will be if the current draft Budget is agreed. The proposed Budget will cause pain and distress to the most vulnerable in society.

I turn now to the proposed capital Budget. As it stands, the proposed capital allocation of £842 million is half of what is needed. Although £842 million sounds like a lot, 50% of that will have to be spent on maintaining existing buildings. Many of those buildings are more than 50 years old, and we must ensure that they are safe for patients and staff. When we take out the maintenance costs and contractual agreements, we are left with £300 million to spend on new buildings over the next four years. If the draft Budget stands, a long list of previously planned capital projects may no longer be delivered.

I will address two further capital issues that were mentioned, without any warning to me, in the draft Budget statement. Despite claims that the Fire and Rescue Service training centre at Desertcreat and the new satellite radiotherapy unit at Altnagelvin Area Hospital can proceed, I have to inform the Committee that, under the draft Budget proposals, health and social care does not have the revenue to run those projects. I very much regret that situation, but that is the reality of the failure of the draft Budget. It would be highly irresponsible to commence any newbuild project without having the funding in place to staff and equip it.

I will turn now to the issue of protection for health. The draft Budget document claims that the health part of my budget has been given broadly similar levels of protection to those in

England. That is a myth. Northern Ireland has been given a lower settlement than England. In the first year alone of the Budget period, England has a real terms increase of 1%, compared with a real terms decrease of 1% here. If the health budget in Northern Ireland were given the same protection as that in England, the budget would be £4·8 billion by year four. In year one alone, an extra £80 million would be available to deliver front-line services. That £4·8 billion would still be well short of the projected need, but it would at least give the health and social care service a fighting chance of manning services over the next four years. Official Treasury figures indicate that Northern Ireland now has the worst funded health service in the UK in comparison with England, Scotland and Wales. The draft Budget proposals worsen that position by ignoring that point. The proposed reductions would mean that, for the first time in more than 60 years, Health Service decisions will be led by money, not by need or quality. That is simply unacceptable and will be hugely damaging.

In conclusion, let me repeat that the draft Budget is not yet a done deal. Two issues need to be addressed immediately. First, the draft Budget settlement for year one must be reprofiled, and failure to do that will result in a potential breakdown of the whole health, social care and public safety system. Secondly, additional revenue must be found to meet increasing demands and to give the same level of protection as in England. Money must be diverted to health so that we can continue to look after the most vulnerable in society. The money is available. I ask for the Committee's support and assistance in delivering those two objectives, and I ask members to scrutinise the draft health budget carefully. The future of health, social care and public safety is now in the hands of the Committee, the Assembly and the Executive.

The Chairperson:

It is difficult to know where to start. You said that the health budget in Northern Ireland has been treated less favourably than that in GB. My understanding is that the Minister of Finance and Personnel has taken the same policy decision as his counterparts in GB by ring-fencing and giving protection to the health element of your budget. Social care is a council issue in GB. Is the issue that he has not ring-fenced enough or that he has not allocated enough to facilitate that ring-fencing?

The Minister of Health, Social Services and Public Safety:

You have misunderstood the situation in England, so I will explain. England will receive, on the health side, an 11% cash increase that will deliver a 1·3% real terms increase. In addition,

because local government delivers many social services, an extra £2 billion will go into social services in England to ensure that delivery levels are maintained. The expectation is that existing levels of social care will be maintained because of that extra allocation in England.

I do not believe that we can separate health from social care, and I am sure that many members will agree. We cannot separate looking after vulnerable elderly people or child protection, and we cannot separate how we look after clients with learning disabilities and mental-health issues — that is part of the whole Bamford agenda — and say that those are not part of health. Although they come under a different heading, they are part of health. However, in Northern Ireland, we will get a 7% cash increase over the next four years. That works out, in real terms, as a 2% decrease. The money will decrease, and what it will be able to buy at the end of year four will be down by 2%, but the demands are rising. There is an increasing elderly population, vulnerable people need support in their homes, and we have to support child protection, learning disability, mental health and acute and primary healthcare.

Therefore, it is a simple matter. We are able to project our need. Although the money has increased, the real effect of a 7% cash increase is different. We have all heard of inflation. Inflation will, effectively, render that 7% increase a loss and will result in a 2% reduction in real terms at the end of four years. After those four years, we will not be able to fund what we fund now, never mind fund the increase in demand.

If we take another perspective and say that 70% of the budget is to protect health — I do not believe that we can do that — that means a 12% cut for social services and a 12% cut for the Fire and Rescue Service. That will have dramatic effects on the numbers of, for example, domiciliary care packages. We look after 29,000 or 30,000 vulnerable folk in their own homes, and they need support, without which they would end up in hospital. If 12%is taken out of that budget — it is already inadequate, and you have heard me say that over and over again — and 12% is taken out of the fire budget, where will that leave the fire stations, firemen and the Fire and Rescue Service? Bear in mind the huge contribution that they made to alleviate the recent winter pressures, when several important facilities were without water. Consider that England will receive an 11% increase, which equates to a 1·3% real terms increase. We are due to receive a 7% cash increase, which equates to a cut of approximately 2·4% over four years.

The Chairperson:

You accept, however, that health has been treated much more favourably than the other 11 Departments, in that all of them have had to produce cash cuts.

The Minister of Health, Social Services and Public Safety:

I am the Minister of Health, Social Services and Public Safety. With a Budget of more than £10 billion to be distributed, there is plenty of money in the pot. I face cuts to my budget that are as big as all of the other cuts put together. As I have told you over and over again, before we got into the current situation, the Health Service was £600 million behind England on a pro rata basis. I did a deal on the budget so that I would not be involved in monitoring rounds, and so on. I was entitled to bid for funds to deal with the swine flu pandemic. However, when I bid for £42 million, I got £5 million and had to find the remaining £37 million myself — that was a cut.

Then, there was the "black hole" Budget, when we discovered a shortfall of almost £400 million in the money available, and that was apportioned to Departments. Health, which should not have been involved in the monitoring rounds, was nailed for, I think, £116 million — another cut. The damage that those cuts did was in-year, and I have explained that to the Committee. Therefore, we are already running well under in financial terms, in addition to which we face these cuts.

I have said over and over again that, if there is not enough money, spend must be prioritised. Any housewife will tell you that. A housewife goes to the shops and buys what she needs for the family, rather than buying other things. As an Executive, we are in the same position, and we should, therefore, prioritise our spend. Health and social care, education and, arguably, law and order are the key priorities. However, that is not a matter for me. I am just one voice out of 108 and one voice at the Executive.

When the draft Budget came to the Executive, I was one of the Ministers that refused to vote for it, and I will not vote for it as it stands. However, we are where we are. If you consider comparisons with the rest of the UK, it is clear that, even before the current economic situation, we had the worst-funded health service in the UK.

The Chairperson:

Do you accept that the first call for the £20 million monitoring round money in June will come to

you as usual? Is it taken as read that an extra £20 million will come from that source? My understanding is that that protocol still applies, so that, although you do not bid for monitoring round money, you receive the first £20 million that becomes available.

The Minister of Health, Social Services and Public Safety:

That is not mentioned in the papers.

The Chairperson:

We will check that, but, as I understand it —

The Minister of Health, Social Services and Public Safety:

It is not in the papers, Jim, honestly.

The Chairperson:

OK. We will move on to Desertcreat. My understanding is that the Minister has made available the £30 million contribution that you require to pay for the Fire and Rescue Service training element of that project.

The Minister of Health, Social Services and Public Safety:

I have never been told that. All that I have seen is a statement.

The Chairperson:

The Minister has announced that.

The Minister of Health, Social Services and Public Safety:

He announced that the money would be available for Desertcreat, but he did not say where it would come from. Perhaps that is the reason that my capital budget is so light, but I do not know.

The Chairperson:

Implicit in his statement is that he will make that £30 million available, which would enable that £160 million capital investment project to go ahead.

The Minister of Health, Social Services and Public Safety:

Jim, you will know that the big bucks are often in the resource required. The building would

have to be equipped and staffed, not just in year one, but for ever. The first criterion that has to be satisfied in a business case to the Department of Finance and Personnel (DFP) is ensuring that resources are available to do exactly that. I do not have those resources.

The Chairperson:

You do not have the resources in this comprehensive spending review (CSR) period, but presumably by the time the project has been commissioned, built and open, you would be into year four of that period. It would, therefore, simply be a question of leaving it until year five.

The Minister of Health, Social Services and Public Safety:

DFP does not allow us to do that. As you are aware, Andrew worked in DFP for a number of years, so he will explain how the process works.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):

It is a condition of business cases that we have to be able to give a commitment that the revenue resources are affordable on an ongoing basis. That is necessary in any business case. To be able to get to square one on this particular project, even to seek approval for it, we have to be able to say that we can sustain it and provide the recurrent resources to, as the Minister said, staff, equip, maintain and run the operation for the lifetime of the project.

We are looking ahead to the years even beyond the period covered by the Budget. If we take the level of reduction required to reach a much lower level of spending, that changes the whole balance of what we can and cannot afford. We will have to examine everything critically. Many difficult things will have happened by the time we reach 2014-15. Given the degree of the challenge that we face, it is unrealistic to ask us, at this stage, to give an absolute commitment to continue to train Fire and Rescue Service personnel in that new environment. The same applies to many other revenue projects. We must be sure that projects are absolutely worthwhile, even in what is a radically different financial context, and that changes everything for us.

The Chairperson:

The problem is that the money at the capital end and at the Department of Justice is there. Unless you come up with your £30 million and your running costs, one of the biggest infrastructure projects in Northern Ireland will not go ahead. That will have major implications for the mid-

Ulster economy, because it is a huge construction contract that is desperately needed.

There is also the radiotherapy unit at Altnagelvin. Surely, for the sake of a few hundred thousand pounds of running costs, you are not suggesting that you will endanger projects for which a huge amount of funding has already been guaranteed. My understanding is that, from the Fire and Rescue Service's point of view, an additional £400,000 a year is required to run Desertcreat

The Minister of Health, Social Services and Public Safety:

I do not know where you got the figure of £400,000 from, Jim, or whether that, too, has been plucked out of the air. I will turn the question back on you: will you jeopardise the major infrastructure project in mid-Ulster by hammering the health budget again? John Compton will talk to you about Altnagelvin.

Mr John Compton (Health and Social Care Board):

Altnagelvin is a major project to which we are strongly committed. The additional running costs will be in the order of £7 million per annum. It is hugely expensive, because it is a radiotherapy project with all the attendant issues. As the draft Budget is constructed currently, there is no prospect of the board, as a commissioner, being able to make any assertion that we could support the opening of that building. We simply do not have the revenue money for that.

The important issue is that, although that building is scheduled to open in 2015 or 2016, because of the nature of the project, we would have to commence the revenue commitment next year. We would have to start signalling to the oncology, radiotherapy and radiography services that we wanted additional people to be trained. The expertise required to run and staff that building cannot be created in a matter of months; it takes several years. To enable the building to open in the 2014-16 period, we would need to plan for that from next year.

As the draft Budget has been explained to me, I see no prospect of how we, as the Health and Social Care Board, would be able to find £7·5 million to run that project. The only option for us to do that, if it were deemed a priority, would be to take £7·5 million from the existing services in the west. Remember that we allocate money on a capitation and fair-share basis. We would have to discount the radiotherapy element that applies to the northern part of the Province. We would then have to turn to the west and say that, to generate the revenue to allow us to open the

building, it would have to shut services to the tune of between £6 million and £7 million. If the draft Budget remains in its current shape, those are the types of decisions that will be taken and with which we will be faced.

The Chairperson:

John, you know the consequences of what you are saying. The Irish Government have €16 million of capital spending coming forward. At the last count —

Mr Compton:

I absolutely know the consequences. None of this is straightforward. I do not take any pleasure in, or derive any joy from signalling what would happen, but I have to be realistic. I cannot advise a Minister nor can I, as I am required to do, sign off on a business case that states that we have the revenue to run that building when I know that we do not.

Moreover, to generate the revenue for that and other new buildings in that time would require us to take pretty unacceptable decisions about the level of existing services. If capital money is available, I want to use it and support its being invested, but I must be concerned with revenue and the ability to run the building once it is opened. You can imagine the shouting that there would be if the building were officially to open but remain closed.

The Chairperson:

I am not certain whether the project will cost £60 million or whether the Irish contribution is £60 million.

The Minister of Health, Social Services and Public Safety:

The Irish contribution is not £60 million.

The Chairperson:

I think that the Irish Government's contribution is half the capital cost.

The Minister of Health, Social Services and Public Safety:

It is not; it is less than that. I cannot remember the exact figure, although it is a substantial amount.

The Chairperson:

The point is that that money is still pledged, and we run the risk of losing it if we do not go ahead with the project.

The Minister of Health, Social Services and Public Safety:

That will depend on the new Irish Government when it comes in.

Ms S Ramsey:

You could say that it depends on the new Government coming in here.

The Minister of Health, Social Services and Public Safety:

I do not have a signed, sealed and stamped legal document that states that we will —

The Chairperson:

As you know, Minister, letters have gone back and forward frequently. In fact, Brian Lenihan, the Minister for Finance, was here today, and, having been written to repeatedly, he has always committed to the project.

The Minister of Health, Social Services and Public Safety:

Equally, you know that I said over and again that Altnagelvin was one of my top priorities, but I need the money to proceed with it.

Mrs O'Neill:

Perhaps, Minister, you should have taken the opportunity to discuss the project with Brian Lenihan while he was here today.

The Minister of Health, Social Services and Public Safety:

I did not know that he was coming here today, Michelle. If only you had told me, I would have done exactly that, and he would have told me to talk to the Health Minister.

Mrs O'Neill:

I will look after your diary from now on, Minister. You said that it is not a done deal, and we accept that it is a draft Budget, but, to be clear, you said that Sammy Wilson made a bogus claim in the House that there was some element of protection of the health budget.

The Minister of Health, Social Services and Public Safety:

I said what I said.

Mrs O'Neill:

You said "bogus claim".

The Minister of Health, Social Services and Public Safety:

Yes. I said that any claim that the health budget — my budget — is protected is bogus. As things stand, I receive a 7% cash increase, but I cannot even start to look at demand and say that I will provide health and social care in four years from now. To do so would ignore a population increase because of a higher birth rate and more extra elderly and vulnerable people who need care. Given that we face a 2·4% real terms decrease by the end of year 4, any suggestion that my budget is being protected is bogus.

Mrs O'Neill:

I will pick up on a few points, particularly on your spending proposals, which are absent. Your consultation document will be released at 3.00 pm, but it is politicking and laying out certain scenarios. In your opening remarks, you said that you have had no opportunity to plan for the year ahead. What have you been doing? The draft Budget may not have come forward when it was supposed to, but surely you were planning for various scenarios? Surely that work was going on in your Department? The paper that you have given us shows bids that were made back in November. It contains nothing new; we have had those for two months. Where are your spending plans? Where is your savings delivery plan? Where is the detail? You and your colleagues on the Committee are keen to put forward motions asking for support to ring-fence health? How can you ask us to support something of which we have no detail? Your document, for example, refers to the loss of 4,000 jobs. Where is the detailed breakdown of where those jobs will be lost? You are not giving us that information, so we cannot assist you.

The Minister of Health, Social Services and Public Safety:

First, we go to consultation at a higher level. Do you have any idea what a commissioning plan looks like? Spending plans in the Health Service are in the form of a commissioning plan. I indicate to the Health and Social Care Board what the budget is, and it produces a commissioning plan. There is a huge amount of work in that. A commissioning plan for £4·6 billion is radically

different from one based on, for example, £4·8 billion, and much of that spend will be based on need and quality. I am telling you that the difference between the two will cause approximately 4,000 job losses. If you want to know where those job losses will be, the plan will have to be developed further. In fact, by the time that happens, I will not be here. I will not be your Minister, and it will be up to another Minister to deliver the plan.

The profile for year one is particularly bad. We are £200 million short in year one. Redundancies will not solve that, Michelle, because they cost a great deal of money to implement. We cannot get our money from redundancies, nor from closures, which are also expensive. We will have to find the money elsewhere. Effectively, if that direction is taken, it targets areas in which cash is spent.

I will ask John to comment, because the consultation is pitched at a much higher level. It is not a matter of my saying what will happen to, for example, the upper floor of the South Tyrone Hospital in Dungannon or the GP practice in Magherafelt. However, once we receive a firm amount of money, away we will go. That money will have to last for four years. There is a huge amount of work to do on the commissioning plan, and there is a huge difference in producing a plan according to money and doing one according to need and quality. We have never produced a plan according to money before.

Mr Compton:

As currently presented, the draft Budget means that we will be short of £200 million in cash a number of weeks after it is confirmed. In health and social care, the only areas in which we can control cash are those with cash flow. I advised the Minister that that would mean substantial restrictions in, and rationing of, community care packages. It would mean, for example, the introduction of a quota system across a trust area so that only a certain number of people would receive a service each month. Once that quota was exhausted, people would have to queue for that service. That is a way of controlling cash.

I also advised the Minister that we would have to shift waiting times. That would negate our progress on the nine weeks, nine weeks and 13 weeks waiting times. Waiting times would increase to somewhere between 36 weeks and 52 weeks for the vast majority of specialties, and that would happen while people were in the middle of receiving those services. Those extended waiting times would not apply to the tiny number of subregional specialties for which there are

long waiting lists. Rather, they would apply to the generic, ordinary, everyday specialty treatments that people receive.

We would have to review our process of grant aid to voluntary organisations. It would be impossible to exclude them, because that grant aid is also a matter of cash control. The difference between managing a budget of £4·6 billion and managing a budget of £4·8 billion, with proper phasing across the four years, is enormous. The difference in the nature of the commissioning plans for the delivery of health and social care in each case is the difference between black and white.

Members will know that a considerable effort has been made to get to a break-even position this year. A key plank of that effort has been the imposition of strict controls on the numbers in the workforce. The 1,500-odd posts that are being controlled currently would have to be removed — full stop. They would not be temporarily lost to the Health Service, but permanently removed. We would have to talk to each organisation about the nature of that loss. The impact on jobs would be direct and immediate.

We would also have to control cash in relation to agency and locum spend. There are positives in that, but placing cash limits on that spend is negative. In practice, that would mean that, when responsible requirements for agency staff and locums occurred, perhaps on a Thursday night, those staff would not be employed that night. The facility concerned would close at one hour's notice, because we might not be able to staff it adequately overnight. Those are the sorts of issues that would arise as a result of the draft Budget as it is currently constructed.

With £40 million of cash in year one, it would be unstoppable to take our spend to £200 million. We have no control, for example, over National Insurance contributions, which will add substantially to our cost pressures next year. This year, we have partly opened buildings, such as the critical care complex on the Ulster Hospital site, which has been open for three months, but for which we will have to pay the full 12 months next year. We had to pay only a quarter of the revenue this year, but we will have to pay the full revenue next year. Those cash expenditures are not containable, and they mean that we need the £200 million. That is why the draft Budget, particularly its profile in year one, is so difficult to manage.

I can only advise the Minister, with the help of my best offices, about the sorts of issues that

would arise. The switching to a more phased position and matching the English settlement of £4·8 billion would enable us materially to plan any transition, to provide quality and to be the driving force in that transition. However, to be able to live within the constraints of the draft Budget would require us to exercise crude cash control. I have put on record how alarmed I am at some of the implications that that would have right across the system. In the midst of that, I am being asked whether I support Altnagelvin and whether, as a senior official, I can guarantee that we have the revenue to support that. Members will appreciate that I had to recommend that it would be completely impossible to give that commitment. .

Another major issue is that we could not provide for the additional number of people who require new and important drug treatments, because we would not have the cash to pay for them. We would, therefore, move to the very outer edges of performance in contrast to the rest of the UK, because the budgets in England and Scotland are of a different proportion and scale, particularly in year one.

Again, cash control will determine the type of commissioning plan that I present to the Minister. As I stated, if I get one set of numbers, I will produce a commissioning plan indicating, detailing and enumerating what I told the Committee would have to happen. However, if I received a budget of, say, £4·8 billion, which was phased more effectively, the situation would be entirely different. We would then have the opportunity to take proper, prudent and correct actions to reform the delivery of our modern health and social care system.

The Minister of Health, Social Services and Public Safety:

It still would not be a bed of roses; it would remain extraordinarily difficult.

Mrs O'Neill:

John, your paper states that, according to the board's work, you will need £5·4 billion by 2014-15, but that you could live with £4·8 billion.

Mr Compton:

It is important to understand how we arrived at the figure of £5·4 billion.

Mrs O'Neill:

Sorry, before you do that, I want to know how you could live with £4·8 billion when your paper

states that you need £5·4 billion. What could you do without?

Mr Compton:

You need to understand how we arrived at that total. However, it is not as simple as just adding and subtracting numbers. We arrived at the £5·4 billion figure by understanding how much we will need to spend over a period on a range of areas: demography, which is the older population; increased demand, such as for new drugs and different types of treatment; accommodating inflation caused by additional rates and utility prices over a period. If you look at it that way, you will understand how we arrived at £5·4 billion.

As we told the Minister, we realise that the world is in a difficult place. If we had to put our shoulder to the wheel, how could we do that? The £4·8 billion is predicated on two elements: our achieving some cash efficiency, and our becoming more efficient to enable us to absorb some of the pressure that we will face in years three and four. It is a difficult ask for us. It is neither straightforward, nor a done deal. However, the tipping point in money terms is £4·8 billion. When our budget goes below £4·8 billion and is presented in the way that it is currently, there is not a gradual downward slope, but a falling off the edge.

I cannot emphasise enough that, given the way in which the draft Budget is currently constructed, with only £40 million more in year one, there is no prospect of the system, in its current configuration, breaking even. Given how the system spends its cash, brutal decisions will have to be taken. Even if we said to the workforce that there had to be many redundancies, although I do not particularly support that, it would still take time and cost money to bring that about. The same applies to closing a site. If the draft Budget were approved, we would need to find £200 million some six to seven weeks later. On 1 April 2011, we would need to be able to spend £200 million less cash, and that is what makes the situation so critical.

Mrs O'Neill:

OK. I want to pick up on some of the figures that make up that £4·8 billion. The first bid relates to demographics, including family health services. The amount bid for in the first year is £55 million, but it then goes up to £112 million. Why does that figure more than double in the first year?

Mr Compton:

The £55 million is repeatedly added to.

Mrs O'Neill:

OK. In the consultation document, you refer to the Department's strategy for delivering the necessary reductions. You pick out five areas on which you will focus, including the reconfiguration of services and seeking greater contributions from service users. What exactly do you mean?

Mr Compton:

That is a reference to charging. On the social care side of the house, if someone in the rest of the UK is in receipt of a community care package at home, he or she is means tested and makes a contribution, usually from the state benefits awarded because of particular complicated needs. Those sorts of areas may have to be considered to generate cash and income, which must be found early to make the budget work. No one is saying that such charging will happen, but it is the kind of area to which we must give some thought. There is no other way of getting past that, because £200 million in year one is a huge amount of money. With six weeks' notice, I do not see any way to find that money other than by growing the level of income coming into the system, which means charging, and controlling the amount of cash that leaves the system, which is the active constraint of where there is direct control of the cash. It is a crude and unplanned method, and it is not how anybody would want to do it. My advice to the Minister is that, for the first time in my career, decisions about health and social care will be front and centre driven by the need to control cash, not by the need of the individual or by the need to provide equality. If we had to control the budget to that figure in that way, there would be no alternative.

Mr Gallagher:

I want to ask the Minister about new buildings, their affordability and whether they will open. Will you confirm that the Enniskillen hospital will open? Furthermore, will you confirm that it will stay open, unlike, for example, the Downe Hospital, which the Department opened and began closing again?

The Minister of Health, Social Services and Public Safety:

That is not the case. The services in the Downe Hospital have increased. Whoever told you that —

Mr Gallagher:

Some beds have gone.

The Minister of Health, Social Services and Public Safety:

There is more activity in the Downe Hospital now than there was previously. Beds have gone all over the show, Tommy, because we have shorter bed stays —

Mr Gallagher:

Enniskillen is the main —

The Minister of Health, Social Services and Public Safety:

I thought that you were majoring on the Downe Hospital. I am happy to talk about that. In fact, John was the one who planned the Downe Hospital originally, so he can talk at length —

Ms S Ramsey:

John McCallister? *[Laughter.]*

Mr McCallister:

I am happy for that to be leaked.

Ms S Ramsey:

Is there favouritism here?

The Minister of Health, Social Services and Public Safety:

I was talking about John Compton to my left. Of course, John McCallister played a huge role in delivering the Downe Hospital. All of the electors in South Down know that.

The Chairperson:

I rule that entirely out of order. *[Laughter.]*

The Minister of Health, Social Services and Public Safety:

As far as Enniskillen is concerned, Tom, you know that we were driven down the PFI avenue of procurement. In fact, we are paying for it as we go along. We have no choice: it is a legal and

contractual obligation. Although I took a lot of the sting out of it through allocating money upfront, and so on, there is still a considerable sting as far as the revenue consequences are concerned. I certainly envisage the hospital in Enniskillen opening and playing an important role, which is what I want. When people start to talk about capital, they should go to see the Enniskillen hospital. That is what a modern acute hospital should look like. Then, visit the Ulster Hospital to see what that acute hospital looks like. You will see what happens as a result of the starvation of capital in health over a number of years.

Mr Gallagher:

I suppose that that was a brighter piece of news.

We all understand that there are difficulties. The possibility of charging was mentioned. The first trigger in most people's minds is what they regard as wastage in the present system. It would be useful if you could give us information that relates to specific examples. The difficulty of funding domiciliary care packages was mentioned. When certain patients are in hospital beds, medical staff say that they should be elsewhere. A hospital bed costs more than £2,000 a week, yet the trusts say that, although beds are available in nursing homes, they do not have the money to provide them. That does not seem to make sense economically, nor is it wise planning. Also, across the trusts, some £5 million a year is spent on taxis.

John mentioned agency staff. A considerable amount of money is spent on agency staff, and John suggested that that might be examined. The employment of locums by the trusts also gives rise to questions. Figures showed that the Belfast Trust spent more than £20 million over three years employing locums and that the Western Trust spent around £16 million. Is there an explanation for that? It seems to be a huge sum of money, and, if there were a better workforce arrangement, surely savings could be found there.

The Minister of Health, Social Services and Public Safety:

I will ask John to come in on that, because that is an operational matter. Let me tell you that I will not be the Minister who introduces charging. As it stands, just to keep a Health Service going, at a lesser level than now and not even meeting need, income must be increased and expenditure must be decreased. There is no other way out of it. As a Government and Assembly, we have a deal with the population to provide cradle-to-grave healthcare according to need and free at the point of delivery. If we fail to do so, that is a major issue for the electorate, but I

assure you that I will not put my hand up for any Budget that calls for charging. In addition, there is no way that I will put my hand up for any Budget that puts 4,000 Health Service workers on the dole.

I would never say that there is no waste in the system. I seek to eliminate waste, and I have done so. Over the past four years, I have reorganised completely the way in which the Health Service is managed and run. The number of trusts has been reduced from 19 to six, and the number of boards has been reduced from four to one. The Business Services Organisation was set up, there is a single central procurement process and the Patient and Client Council was established to give us feedback from users and patients. We have made major changes, and, although I would never say that there is no waste, we have gone a long way in eliminating it, particularly through those steps. John will address the issue of taxis. I was hoping to talk about the shortfall of £200 million, but I am happy to talk about taxis and locums.

Mr Compton:

Mr Gallagher, you raised three issues. You asked why someone cannot be moved from a hospital bed costing x to a community bed costing y that is more efficient. That can be done only by closing the hospital bed. It is one piece of money, not two. If you consider that someone in a bed needs to be there, but you want to move the money, you would have to close the hospital ward. If that hospital ward were to release about £2 million in cash, that money would be invested in buying the nursing home places. It must be understood that there is no straightforward reluctance to do that. My point is that that one piece of cash can be spent in one place or in another place. That is why we need to size where we are and why we change the number of beds in hospitals.

Mr Gallagher:

Could someone take a look at that situation?

Mr Compton:

Of course. That is why the number of beds changes and why there was so much discussion and debate in Downpatrick. People heard that a small number of beds were closing in the Downe Hospital and there was confusion as to whether we were closing it. No, we are not closing the hospital. The issue is not the number of beds but the access to hospitals. The questions that should be asked are whether we have taken away a service and whether we have reduced the number of potential inpatients. Are we refusing anyone entrance to the hospital? No, we are not.

If we can manage to achieve that more efficiently, with 10 beds instead of 20 beds, we can turn the 10 beds into cash and invest that cash in community care. That is what is required. With a budget of £4·8 billion, we would have a chance of doing that in an orderly way, but we have no prospect of doing it that way with a budget of £4·6 billion.

There has been much talk about taxis, and I understand that the man and woman in the street think that there is something casual or unnecessary in using taxis, because they are generally used on social occasions. In fact, a taxi is often a cheaper form of transport. If a youngster is taken into care and placed in a foster home that is 15 miles away from his or her school, what should we do? Should we transfer such youngsters to different schools or maintain them in the schools in which they are currently enrolled? How do we get them to school in the morning? We use a taxi. It is important to understand what the taxi is used for. It is not used for some social enterprise or arrangement; it is used as part and parcel of the system of care and support that we provide.

The use of agencies and locums is an important issue. This year, significant control has been applied to the expenditure on agency and locum staff. However, agencies and locums are part and parcel of the health system. There will always be times when staff are ill or a recruitment process is ongoing. At such times, we have to employ temporary staff. The issue is the proportion of money that we spend on that. Our task is to size our use of agencies and locums. When that work is complete, it does not mean that we will not use agencies and locums on certain occasions. The approval of senior clinical jobs, as well as the associated necessary processes, takes several months. That does not stop people coming into hospital, nor does it reduce the demand for services. We cover that by employing a locum, pending the full-time recruitment. Often, when we recruit, people have to work three months' notice, for example, so we have to cover that period. Again, it is important to understand how and why locums and agency staff are used. They are not a casual or sloppy use of our monetary resource.

The board spends a great deal of time talking about finance to each of the providing organisations. I assure you that we spend much time examining areas in which it might be possible to do things more efficiently. Like the Minister, we would never say that there are some things that cannot be done or worked at. However, while that work continues, the scale of the money involved does not nearly approach the scale of what is constrained in the Budget.

Over the period of the review of public administration (RPA), we committed to about £50 million of savings, which we are on target to deliver. That shows a strong and robust commitment on the part of the service to give the Minister an opportunity to consider his budget. He will then ask me what I can do with the available resource.

Mr McCallister:

Thank you. This is a somewhat worrying discussion. You have been successful in meeting your RPA targets and making savings from doing so. Minister, yours is the only Department to have done that. Perhaps you were almost too successful, because the draft Budget places you in a difficult situation. You always made it clear that even the previous Budget settlement was difficult.

You mentioned, Minister, that health in England will receive a cash increase of 11%, whereas health in Northern Ireland is due to receive only 7%. How did we end up with such a difference? Is it purely a case of DFP holding that money back? In light of the coalition Government's protection of health, surely we should receive 11%, too.

The Minister of Health, Social Services and Public Safety:

I will ask Andrew to talk about that, because he was involved with the Treasury. In England, health received an 11% cash increase, which translates into a real terms increase of a 1·3%. In addition, £2 billion was provided to protect social services. It is expected, therefore, that the level of social services will be maintained. We are due to receive a 7% cash increase for health and social care. That means that our budget in real terms goes down by 2·4%. That is exactly where we are, despite the coalition Government's having said that they would send over enough money to protect the Health Service.

Dr McCormick:

That is correct. The Chancellor said in his statement on the spending review that the Barnett formula would work out so that the money would exist to enable all three devolved Administrations to follow broadly the same pattern. Of course, it is a matter for each devolved Administration to makes its own judgements, and the issue now before us is what judgements should be made.

The way it worked in England was that health was given a high priority. Action was taken

specifically to protect social care, as the Minister explained. That led to the level of allocation available to the Health Service there and to the deeper reductions that apply to other services across the water. There is a greater differential and a much stronger prioritisation of health in England than in the pattern of proposals before us now. That is how devolution works: the money comes across through the Barnett formula, and it is for the Executive and Assembly to make judgements.

We are drawing out the facts in a situation in which many aspects of health and social care are strongly paralleled by what is happening in England. Fundamentally, health and social care staff have parity of pay, and we attempt to match the levels of provision for new drugs through NICE guidance. We try to provide the same standard of National Health Service provision. The issue that is increasingly emerging is that our funding basis is completely different, which makes providing those same standards extremely difficult.

Mr McCallister:

Surely, Minister, it is unsatisfactory for the Executive and Assembly to conduct their business by giving you the draft Budget five or six minutes before the Executive meeting. One Minister even made announcements about Desertcreat and Altnagelvin without your knowing whether the money for those projects was in your budget. Is that not a bizarre way to run any organisation?

The Minister of Health, Social Services and Public Safety:

That reinforces the charge that the Executive are dysfunctional. I sat there as the Health Minister listening to the Finance Minister, when he threw in the announcements on Desertcreat and Altnagelvin without having informed me. That was unusual, to say the least.

I received the draft Budget paper at 5pm on the afternoon. There was due to be a meeting of the Budget review group, but that did not happen. Danny Kennedy was handed a paper, and we studied it together. Then, we sat around for several hours before a meeting of the Executive was called. We were asked to vote for the draft Budget. I refused to vote for it, as did Danny Kennedy. I am not giving away any secrets when I say that Alex Attwood also refused to vote for it. The other parties — DUP, Sinn Féin and the Alliance Party — voted for the proposals, which subsequently came before the House. Even then, however, I was not aware until that afternoon that those two capital projects were included. The obvious point to make was that Altnagelvin, as I have said over and over again, was one of my top four priorities for capital development. Based

on the allocation, however, I did not have the money to staff or equip it.

Mr McCallister:

If we turn to the £200 million and consider the demographics of the population, I can see that that will have a serious impact. You mentioned the higher birth rate and the ageing population, and, as Minister, you have consistently stated in the Assembly that the first and last 10 years of life include the highest rate of Health Service use, so there will be pressures there. Where do you see this going?

You also mentioned the community and voluntary sector. The draft budget will have a serious impact on new service developments, early intervention and any preventative work that the Department wants to do.

John, you spoke about the impact on waiting lists and waiting times and said that that will put some of those costs off into another financial year. Is that really what you mean by driving this from a financial perspective rather than on a medical and needs-driven basis? As the budgetary process is so late, will those costs be moved from the incoming year to future years simply to try to live within that £200 million?

(The Deputy Chairperson [Mrs O'Neill] in the Chair)

The Minister of Health, Social Services and Public Safety:

There are substantial demand pressures. Even if I take the whole lot locally as one budget, it is minus 2·4% in real terms at the end of four years. People need the Health Service most between the ages of nought and 16 and when they are over the age of 65. Currently, our over-65 cohort stands at 15% of the population. That will go up by around 50,000 in the next five years, which is roughly the length of this budgetary process and a wee bit beyond. That is the increase in demand at which we are looking for that cohort. The cohort of over-75s and over-85s is also increasing, and there is not a halfpenny in the budget for that.

New drugs are coming on the market, and there is nothing for that. There are new procedures, and there is nothing for that. We have a rising population, with the highest birth rate in the UK, and no allowance is made for that. That is the demand, for which £4·8 billion does not account.

I am trying to make the best deal that I can for the Health Service for the next four years. At £4·8 billion, we can at least argue that that is roughly the same as the English settlement. However, England is already £640 million ahead, and that gap will grow by a further £200 million. If the provision at least goes to £4·8 billion, the gap would be maintained at the same level. We could then examine what we could do by way of efficiencies. Again, that is no bed of roses.

Effectively, that is what we are looking at. It is a matter for all of us. It is not my Health Service; it is your Health Service. It is the Health Service for the Assembly and the Executive. I am firmly of the view that, overwhelmingly, the population believes strongly in the Health Service, wants to support it and considers it a priority. We should reflect that.

Ms S Ramsey:

I take this opportunity to welcome the Minister and his team and to wish them a happy new year. That is the positive out of the way. *[Laughter.]*

The Minister of Health, Social Services and Public Safety:

And the same to you.

Ms S Ramsey:

I am surprised that the deputy leader of the Ulster Unionist Party did not mention that his sister party created this cut in the block grant. We should not lose sight of that fact.

Mr McCallister:

I will clarify: it was our sister party, to use your term, that gave a commitment to protect health. You heard the Minister say that health is being protected by 11%.

The Deputy Chairperson:

John, you have had your turn.

The Minister of Health, Social Services and Public Safety:

I looked at the parties around the table at the Executive Committee meeting, and I can tell you that they were all Northern Ireland parties.

Ms S Ramsey:

Exactly, but when you get a cake you have to decide a cut.

The Deputy Chairperson:

Allow Sue to ask her questions.

Ms S Ramsey:

Nobody, including me, is disputing the fact that there is a history of underfunding in health in general and that we get confused when we talk about health and social services. However, the fact is that there has also been a history of wastage in health, which has led to public outcry. Recently, the issue of excessive travel was raised. I partly understand that some training has to take place and that we need to live in the real world. Another issue is bonuses, pay awards, distinction or merit awards — whatever we want to call them.

(The Chairperson [Mr Wells] in the Chair)

There is also the issue of ongoing bed blocking. Let me give you a recent example: the other day, I was speaking to someone who is waiting for a scan and has been in hospital for six days. When people speak about bed blocking, therefore, it is not necessarily because of the need for a community care grant: simple procedures are not being followed.

I will refer specifically to your paper. In some senses, it provides detail, but it does not provide enough detail. I would appreciate it if you could look at that and provide us with more detail. As regards the Altnagelvin and Desertcreat projects, will you give us an idea of when you or your officials were last in contact with the Irish Government or with other Ministers to discuss those two projects specifically? We need that information. If some blockage exists that prevents that from proceeding, we need to know about it. Do officials not talk to one another?

The budget bid is outlined in appendix A of the briefing paper. I am interested to have more detail on the £250 bonuses that are to be paid to staff who earn under £21,000. When those figures are rounded up, they amount to £9 million, £18 million, £18 million and £18 million over the four-year period. What is that about? I am also struck by the statement in the document that there is the possibility of 4,000 job losses. Why does that figure double in one year? Where will those job losses be? People want those answers.

Having taken on board the other distinction/merit awards, bonuses or pay awards — whatever we want to call them — that we are looking at, I think about Agenda for Change. The paper states that 11,000 individuals exercised their right to appeal, which is fair enough. Half of them were successful. We are told that the cost to meet grading appeals under Agenda for Change is £15 million in year one, £3 million in year two, over £3 million in year three and over £3 million in year four. How did we get it so wrong? What will be the outcome of that? Half of 11,000 is 5,500 people. In their cases, we got it wrong. Getting it wrong will cost almost £26 million over the four-year period. Those are the types of questions that I want answers to.

Furthermore, progression in health and social care pay will require over £18 million in year one; almost £40 million in year two; almost £60 million in year three; and almost £80 million in year four. However, you tell us that there is still a possibility of 4,000 job losses and a moratorium on staff recruitment. In my head, that does not fit.

What stage is Investing for Health at? Where are we with that? If Investing for Health were reviewed and up and running again, it would bring in additional revenue, policies and strategies from other Departments. You might like this question, Minister — well, I hope you like it: when you come to your final decision on the budget, will you ensure that it is equality-impact assessed, or will that be screened out? .

The Minister of Health, Social Services and Public Safety:
I will run through some of those issues. I will then call John to come in.

As far as Agenda for Change and progression is concerned, you are well aware that those are national pay deals. They are agreed with the staff side, as is the process. As far as equality is concerned, I will ensure that it is assessed because I was extremely unhappy with how it was handled previously in the black hole Budget. By definition, if a service provides primarily for the elderly population — 75% of the population in hospital beds are people who are over 65 years of age — or provides primarily for the young cohort — people who are aged between nought and 16 years — money is taken off it. There is no equality in that. By definition, that is unfair and should not pass an equality impact assessment. I did not understand that, and I protested about how, when the money was taken from that budget last year — when the Executive discovered that they had nearly £400 million of a black hole in the Budget — that could pass. I was certainly

robust about that.

You talked about travel, Sue, or was that Tommy?

Ms S Ramsey:

No, it was me.

The Minister of Health, Social Services and Public Safety:

I have frozen merit awards. Along with my counterparts in other devolved Administrations, I asked for a review. The then Labour Government were not minded to do so, but the new Government have undertaken a review of merit awards. They are not bonuses; they are merit awards, which are given for outstanding contributions to particular disciplines. I have my own view on those awards and where they should go.

Ms S Ramsey:

I am sorry; did you say that you have frozen them?

The Minister of Health, Social Services and Public Safety:

I have frozen them. No new awards have been made at all.

Ms S Ramsey:

Therefore, whether they are bonuses, distinction awards, merit awards or whatever they are called —

The Minister of Health, Social Services and Public Safety:

No new awards are being made. I have frozen the awards. We still have the existing awards, which are part of the contracts, but no new awards will be granted until the review is completed, after which we will deal with that issue. However, I believe that, when we consider the outstanding achievements of some of our doctors and the rewards that they receive, we are getting very good value for money.

The blockages relating to Desertcreat and Altnagelvin are down to money. My officials and I talk routinely to counterparts in the Irish Republic as we do with those in England, Scotland and Wales. I attended a North/South Ministerial Council meeting in Newry recently and made a

statement to the House a number of weeks ago. That process is ongoing. The blockages are down to money. Our ability to run those facilities, even if we had them built, is the issue.

There has been a lot of newspaper coverage on travel. We spent £350,000 on travel over the past three years. That expenditure, through the safety forum, produced major savings. One in 10 patients suffers an adverse incident when they go into hospital. That could be anything from getting the wrong medicine to slipping on the ward to getting an infection. As I said at the time of the clostridium difficile outbreak, I will do my best to eliminate that virus and MRSA and get them down to acceptable levels. Part of the whole process was about learning different ways to do things. I can show savings of an estimated £1·9 million because of the 54% reduction in surgical site infections. In one year, one hospital made an estimated saving of £200,000 in relation to ventilators associated with pneumonia.

Ms S Ramsey:

I am sorry, Minister. I appreciate that we need to go to places to learn lessons. When we had the presentation, I was one of those who said that we saved a lot of money. I am saying that the public are hearing about bonuses, merit awards and all that, and about money that they believe is being wasted. When we take into account the fact that people who earn under £21,000 are receiving certain bonuses, the increase in wages and Agenda for Change, the public see those as wastage. That is why we need the detail.

The Minister of Health, Social Services and Public Safety:

I will ask Andrew to answer that. By and large, Agenda for Change affected low-paid workers. Those folks are at the bottom end of the scale, and they are getting what I would say is a fair crack of the whip.

Ms S Ramsey:

Somebody made a mistake.

The Minister of Health, Social Services and Public Safety:

We can talk about so-called mistakes. We follow the national pay deal that was agreed with the staff side. That is the fair way to do it. All low-paid staff in Northern Ireland are entitled to the same sort of treatment that they would get if they were working in England, Scotland or Wales.

Ms S Ramsey:

I think that you are being disingenuous by saying that I am attacking low-paid workers, because I am not. Someone has made a mistake. It is easy to make a mistake with public money.

The Minister of Health, Social Services and Public Safety:

I know your commitment to the low-paid workforce, Sue. I am not suggesting otherwise at all. However, I have said what the reality is. I will ask Andrew to comment.

Dr McCormick:

The various bids are all based on the application of current pay policy as we understand it. Some things could change. The policy position is a pay freeze on everyone over £21,000. In appendix A, the line called pay inflation is so low in 2011-12 and 2012-13 because pay is frozen, and we assume, although we do not know, that it will begin to rise in line with normal expectations in 2013-14 and 2014-15. As part of the package, those who earn below £21,000 receive an increase of £250 a year. I do not call that a bonus, but they are not frozen completely. The bid is for the cost of the £250 for the people who are paid less than £21,000 a year. Those are straightforward applications of the pay policy.

Ms S Ramsey:

Why does that rise to close to £18 million the following year?

Dr McCormick:

It is a two-year phenomenon. The pay freeze is for two years, so the people who earn less than £21,000 get £250 in 2011-12 and another £250 in 2012-13. That is our understanding of how the pay freeze will be applied, and that is what gives rise to those bids. It is a straightforward application of pay policy as we understand it.

Ms S Ramsey:

I will be quick, because I am conscious that other members want to get in. If there is a bid for £8,750,000 in year one for the payment of £250, why does it go up to £17,500,000 in year two if only another £250 is being paid out?

Ms Daly:

That is the two years to which the pay freeze applies. They get £250 in year one and that adds on

to the pay bill, and, in year two, they get another £250.

Dr McCormick:

The figures are all cumulative.

Ms Daly:

It flattens out in the last two years because there will be no further bonuses, and there will simply be pay inflation.

Ms S Ramsey:

That is the type of information that we need. We are supposed to sell this to the public. If the media were to look at the figures and see bids of £9 million and £18 million for bonuses over two years, that would be the headline.

Dr McCormick:

Those bids are for the protection of those who are lowest paid from the effects of the pay freeze. There is a bid for the cost in Agenda for Change of incremental progression, and that issue is of live consideration because employers in England are in discussion with trade unions to see whether it is possible to reach an agreement that, in exchange for a guarantee of no compulsory redundancies, staff might be willing to forgo progression. If that were to happen, pay parity would be an issue for us, but we also have the issue of redundancies here. Given that our Budget settlement is imported from England, we cannot guarantee that there will be no compulsory redundancies. That is part of a real dilemma. The principle of pay parity is paramount, but there is an obligation for pay progression in Agenda for Change. That is a really difficult issue.

Bids have been made for the cost of grading appeals not because people got those wrong. They will have carried out the Agenda for Change process in good faith, organisation by organisation and post by post. It has been an exhaustive process that has taken five years or more. In some cases, there are appeals, and those will be considered by tribunals. We will have to accept the consequences of tribunal rulings. Those are unknown at this stage, and we are allowing for them. We are not entirely sure how that will play out and when the money will need to be paid. It is not that people have got it wrong, but, in good faith, employers and the staff side have worked together to seek agreement on the bandings of posts, and some have been reviewed. That is the proper and normal application of the process. All those issues are complex, and they

are an application of the principles of pay in the health and social care system in the best possible way.

The Chairperson:

Andrew, you talk about a pay freeze, yet the health and social care pay increments will cost you £78 million. Effectively, therefore, there is no pay freeze.

Dr McCormick:

Those are contractual entitlements under Agenda for Change.

The Chairperson:

You call them unavoidable costs, but how unavoidable are they? As an independent, devolved Assembly in the United Kingdom, are we bound to follow slavishly a policy that states that someone on £50,000 or £60,000 a year should get his or her increment and that we should pay out £78 million? That £78 million would go a long way to address the concerns that John outlined. That is cash that could be used for front-line care, and many of those people at a more senior level would still earn good money. We are not talking about the people who earn less than £21,000.

Dr McCormick:

The payment to people who earn less than £21,000 is a particular aspect of the pay freeze, but the incremental progression applies to Agenda for Change, whether at the bottom or the top of the scales. Many of the people who are entitled to incremental progression under their contracts of employment will be low paid.

The Chairperson:

Are we going to give them increments, not pay rises, of £78 million?

Dr McCormick:

It is part of the employment contracts. It is how Agenda for Change works.

The Chairperson:

Perhaps the three devolved Administrations and Westminster need to get together and consider, in view of the terribly difficult situation, whether, in return for no redundancies, we can consider that sort of figure. That £78 million figure would save an awful lot of jobs.

Dr McCormick:

The devolved Administrations attend the negotiations in London on this issue. Each devolved Administration will have to consider what course to take. However, that will be conditioned by what is possible. Given that it is a contractual entitlement, staff will have to be willing to forgo the progression. If employers cannot provide some good reasons, why would staff forgo? It is a very difficult issue.

The Chairperson:

We would have staff who would not be happy, but it would have no impact on the front-line care of people in hospital beds and clinics. That is the sort of figure, and that type of money, that we are looking at. It does not affect people on the front line.

Mr Compton:

Everyone is thinking seriously about this issue, but we need to understand who we are talking about. We are talking about the nursing workforce. This is telling nurses, who are perhaps on a five-point salary scale, are at point three and are expecting to move on to points four and five, that they are not doing so. It is important to understand that this applies to what I describe as the engine room of health and social care. It applies to the people who do the job on the ground every day by providing care, treatment and support. It applies to ward managers, team leaders, social workers, occupational therapists and nurses. It is important to understand that those groups of people will experience the consequences of that decision.

The other difficulty and complexity about the total settlement figure is that, even if we get there, because the settlement is so far away from the situation in England, it would be difficult at this juncture to sign a deal that there will be no compulsory redundancies. We need the total picture to be able to get into that position. It is an important and live issue.

Ms S Ramsey:

We need to be careful when we talk about nurses. Not long ago, a decision was taken to increase nurses' pay, and it was not increased here. The argument needs to be made that, if there is parity with England, Scotland and Wales, perhaps we should be thinking about making our own decisions.

Mr Compton:

There is parity.

Ms S Ramsey:

With all due respect, when nurses got a 2% increase a year or two ago, it took a campaign from the Royal College of Nursing for it to be applied here. Representatives came to the Committee, and we had to support their case to get the increase. Sometimes, it suits to say that there are negotiations taking place in London, and other times it does not.

The Minister of Health, Social Services and Public Safety:

Sue, I was a part of that campaign, and I strongly supported the Royal College of Nursing at that time.

Ms S Ramsey:

No one is saying that people should not get what they are entitled to, but sometimes decisions made in London are not followed through here.

Let me move on quickly to Investing for Health. I am sorry for hogging that last discussion.

The Chairperson:

A hardy perennial. Sue asked a question about Investing for Health. Where do we stand with that? We keep asking that question, and we never make any progress.

Ms S Ramsey:

That will be on my headstone.

The Minister of Health, Social Services and Public Safety:

It will probably be on mine as well.

I cannot remember exactly where Investing for Health is now. We reviewed and refreshed it. It is about to be relaunched as a key part of our activities. Although Investing for Health is a cross-departmental strategy, it is not easy to get other Departments to stump up. I will send the Committee a position paper on Investing for Health. I will organise that for you straight away.

Ms S Ramsey:

Thank you.

Mr Easton:

Minister, you will be glad to hear that I am going to be quite nice to you.

[Laughter.]

The Minister of Health, Social Services and Public Safety:

You are always nice to me, Alex.

Ms S Ramsey:

That is his new year's resolution.

Mr Easton:

I am trying to get my head around some of the stuff that you came off with.

[Interruption.]

Perhaps John can explain the £200 million to me. I am trying to get my head around it. You said that if you had £4·8 billion by year four, you could just about survive.

Mr Compton:

It is a big ask.

Mr Easton:

Are you willing to give it a go?

Mr Compton:

Yes, we are.

Mr Easton:

The proposed budget over four years is £4·629 billion, so it is £170 million short in year four, were we to go on year four being £4·8 billion. Does the £200 million apply to every year or just

year four?

Mr Compton:

No. People might say that the figure is £4·63 billion, which is not that far away from £4.8 billion, so why can it not be done at £4·8 billion? However, it is a huge effort to come back from £5·4 billion to £4·8 billion. That is important. Therefore, the £4·8 billion is the tipping point, and when we get to a different place, the budget is tipped to a different end point.

The £200 million in year one is the profiling of the budget. Therefore, to get to £4·63 billion across the four-year period, that is profiled. For example, in year one, our submission states that health and social care will receive about £43 million extra, whereas, in year three, it states that it will receive an additional £115 million. Confronted with a £43 million increase six to eight weeks away from the Budget being applied, were it to run through, and given the current costs that we cannot cease to pay, may lead to a £200 million cash problem in the first year. That is the important issue.

How do we solve that? In my view, we do so by doing two things: by trying to get the budget to £4·8 billion and by re-profiling the allocation in each year to give more cash in year one. That is because what is being asked of our system involves an enormous change to the cash position in the first year, with a view that it may not be as bad when we get to the end. My concern about that is that decisions taken in year one to contain the cash may be horrible enough to threaten the integrity of what we understand as a health and social care system, because we have to control the cash. If we have to do that, 70% of our spend is on people. Since we cannot get the money out with people quickly enough, we must go to the other 30% of the money, and we have to hit it extremely hard to control the cash. That is when there are difficulties about potential restrictions to community care, ceilings, cappings, and so forth, and perhaps people cannot be offered new drug therapy because of cash control. Therefore, it is important to consider those facts as distinct and separate, because they are two different £200 million. It is coincidental that they turn out to be the same figure.

Mr Easton:

If you were to get the £200 million in the first year, would you be able to juggle the second and third years a wee bit better? If you were up to £4·8 billion in year four, could you live with that?

Mr Compton:

The Minister put it well when he stated that the £4·8 billion is one serious push and ask. However, there is a possibility of achieving it, and, if profiling the money across the four years were to be different, we would have the opportunity to plan. That plan would give us the opportunity to put quality and need at the front of how we think about services. As it is currently constructed, we have not enough at the end point, and cash will determine any decision.

In the delivery of health and social care, that is an uncomfortable position for staff, because, although we talk in big numbers, this all plays out in people's homes. It all plays out when we say to people that they are assessed as needing 15 hours a week domiciliary care from now, but that they have to wait eight weeks before it starts. People might be assessed as requiring 15 hours of domiciliary care but will be provided with only five hours for the next eight or nine weeks. Big numbers are one thing, but this plays out — on the ground — at the end of a bed in people's homes, with a doctor telling someone that they need their gall bladder removed. That would normally be organised within 13 weeks, but that person will now have to wait 42 weeks. Such a situation may not curtail a patient's life. However, anyone who knows someone in that position will know that that is most unpleasant and that he or she does not feel well. That is what is being asked, and that is what it would mean.

Mr Easton:

There was talk — I do not know how accurate it was — about the Department having an option to secure capital to revenue, or revenue to capital. Is there any truth to that? Will you describe that to me?

The Minister of Health, Social Services and Public Safety:

The idea is that, because we are so short of revenue, we would take some capital and convert it to revenue. However, the revenue is far below what I anticipated from the discussions, and the capital is also miles below. If we are to keep the system going as opposed to building, we have to do certain things. More than half the money goes on maintenance, and there are contractual commitments to finish jobs. However, we are seriously starved of cash. The Executive have a plan to turn cash revenue into capital. I find that bizarre, bearing in mind the shortage of extra revenue. They also have a scheme called invest to save; I think that it totals about £100 million. I understood that health was to get more than its pro rata share, but we ended up with £12 million. Therefore, £12 million of our extra money in year one is tied up with conditions. There is money

slopping about.

I am trying to find ways to make our budget work. Three years ago in the previous Budget, the settlement was not enough but it was as good as it got. I was making it work, and I could have made it work. On the evidence of waiting times in 2007, 2008 and 2009, the system worked, and I made it work despite the increases in demand. I was then nailed with big cuts — I mentioned some of them — and here we are again. If the budget is £4·8 billion, that is a big ask, but we have an opportunity at least to stave off the evil day in many areas. However, we are playing for time until finances are resolved. Many things need to be done. For example, a situation of 11 Departments with everybody getting a turn is daft. We need to reduce the number of Departments quickly. That would release a lot of cash. If folks had dealt with the RPA in the way that I did, cash would be knocking about. I have agreed terms of reference with the Minister of Finance and Personnel to bring in the performance and efficiency delivery unit (PEDU), and we will look at health issues. However, there is no bucket of gold, and I have lifted all the low-hanging fruit. We must make some very difficult decisions, all of which will need investment.

I am trying to be realistic about the £4·8 billion. If I were the Finance Minister, I assure the Committee that much more money would go to health and education, because those are the priorities. However, we are stuck where we are, and, as John explained, we need to sort out the year one profiles and amounts, otherwise dire and certain things will happen, which I have attempted to portray. It will not be me who does that, Alex. People might be telling you quietly not to worry about it and just blame McGimpsey. McGimpsey will not be here to blame, and everybody will point their fingers elsewhere.

Mr Easton:

Obviously, we will have to look at efficiencies. In the past, I made suggestions that you, at times, pooh-poohed. On a few occasions, you implemented those ideas. However, that aside, we have not tackled or, for some reason, have not wanted to tackle certain issues. For instance, the Committee has met, and I have met privately, representatives from organisations such as Praxis Care, which claims that it can deliver some mental health services 29% cheaper than you can. There is much more scope in the area of generic drugs. France, for example, delivers much more on that front. There are still issues with procurement, which were highlighted in our failure to use one provider to make false limbs and joints. Therefore, there is room for improvement. Text messaging, for instance, has been successful in some countries in addressing the upturn in missed

medical appointments. We could examine other efficiencies, and I hope that you will take that seriously. It is not a criticism, but some areas could be expanded.

My final question is for clarification and for my own peace of mind. Minister, your colleague Mr Gardiner introduced a motion about protecting front-line services and the health element of the budget. I believed that that motion came from you. Some of us supported Sam because we believed that it was the right thing to do. Indeed, I believe that the Minister of Finance and Personnel honoured that. Will you clarify whether the motion came from you or from Sam, because I am a bit confused?

Mr Gardiner:

The motion was from me on my own. The Minister did not try to bribe me or anything like that. It is necessary for health to be protected, and it is unfortunate that the motion did not cover all aspects of it.

Ms S Ramsey:

Not everybody supported it.

Mr Gardiner:

Sinn Féin did not support it.

Mr Easton:

It was a surprise that there seems to be some sort of split. We thought that we were trying to be supportive.

The Minister of Health, Social Services and Public Safety:

There is no split. It would be helpful if we could produce another motion and give you an opportunity to support it and to get consensus for health, social services and public safety, because we have not even talked about the Fire and Rescue Service, and it is going to get hammered.

You made a number of points, Alex, and I do not pooh-pooh them. In fact, I need to eliminate waste everywhere I see it. Rather than trusts buying individually, we now have a central procurement process, which is paying dividends. We set it up on 1 July 2008, so it is reasonably

early days for the organisation, but it is making good advances and has been a huge help for us around pharmacies and pharmacy bills.

We introduced the Go Generic campaign, and, when I came into the Department, around 42% to 43% of drugs were generic. That figure is now around 65%. The target is around 70% to 75%, which is the same as England, and we are rapidly getting there. We cannot go much higher than that because generic drugs only become generic after about 10 years on the shelf. If we were dispensing generic drugs only, we would rule out all the drugs that have been created in the past 10 years.

I have had discussions with Praxis Care, and I am interested in all that, but a key issue is always the level of care that folks receive. As you are aware, there is more to giving care to an elderly person in their home than simply providing care. It is about social intercourse, having time for a chat, assessment, and so on. DNAs (did not attends) are a major bugbear. We have tried many ways to deal with people who did not attend, and I continue to look at that because it is a major problem.

Mr Callaghan:
It may be remiss of me not to be more conspicuous in signalling my intention to ask questions, but I assumed that you would have assumed that I was going to ask something.

Minister, you painted a worrying vista of what you consider to be ahead of us. I will pick up briefly on the issue of Agenda for Change. You said that it was about giving people a "fair crack of the whip". My predecessor, Mark Durkan, raised issues previously about trends in the Western Trust area where people and various cohorts of staff had a sense that there was a differential at subregional level between people west of the Bann, in Altnagelvin and elsewhere in the trust, and people in the greater Belfast area, but I am sure that we will come back to that at another time.

I will stick with Altnagelvin first, and then I will ask you a few more general questions. I want to drill down into the revenue figure of £7·5 million so that we have an appreciation of what is in play here. Is that figure the total estimate for the running cost per annum for all patients coming through the radiotherapy centre, or is that the Northern contribution, given that it is a cross-border project?

The Minister of Health, Social Services and Public Safety:

If you have more questions, you can ask them and allow me to respond.

Mr Callaghan:

My understanding of the satellite project in Altnagelvin is that it is not just for patients in Derry or in the Western Trust, but that it will also fulfil a regional function when the regional cancer centre reaches capacity, which will be around 2015. You said that the money will have to come out of the Western Trust's capitation.

Mr Compton:

That is the net figure.

Mr Callaghan:

I do not understand why the Western Trust's capitation has to take the entire hit if the anticipated patient intake does not relate solely to the Western Trust.

Mr Compton:

I will answer specifically: we have discounted the money that comes from Belfast, the North and the South. The net figure relates to the west.

Mr Callaghan:

Is the figure £7·5 million?

Mr Compton:

The total running cost of the building is actually much greater than that.

Mr Callaghan:

What is the total running cost?

Mr Compton:

From memory, I think that it is around £14 million.

Mr Callaghan:

This is not incidental. Is there an estimate of the Southern contribution to revenue?

Mr Compton:

That is a point of discussion in our meetings with our colleagues from across the border. There is no doubt that they will pay their fair share. We will have to finalise that, and it will have to go to the Minister for inter-governmental agreement. However, I have no doubt that we will find a proper and responsible arrangement if it comes to that point.

Mr Callaghan:

These are fairly significant sums. Presumably, it would be more than even the North's £350,000 quantum. That is not incidental to the Committee as it tries to address some of the issues being presented here today.

People in Derry and elsewhere west of the Bann will tell me tomorrow that this is an accountancy trick between the Department of Health, Social Services and Public Safety and the Department of Finance and Personnel. As money may, or may not, be included in a budget four, five, six or seven years down the line, there will be a sense that it is a case of doing patients west of the Bann out of a much-needed service.

Minister, I am happy for you to come in on those points now.

The Minister of Health, Social Services and Public Safety:

I am always hesitant about coming in the middle of a member's questions because whatever I say spawns more questions. I am genuinely running out of time.

Altnagelvin is one of my key capital priorities. The capital budget is being hammered, and you have to accept the fact that there are also other projects. The ward block in the Ulster Hospital, for example, is in extremely poor shape. I would like you all to go and wander round it and look at it. It has concrete cancer, is 50 years old and is not fixable. I am looking at a bill of £28 million just to put in temporary rewiring for health and safety reasons. If that ward block fails, Belfast's entire acute hospital network will fall over. It is another of my key capital projects.

Altnagelvin is a key capital project because of the cross-border element. Let me tell you that there is no law or anything in the Belfast Agreement or anywhere else that states that I have to do

it. I am doing it because I see real benefits for the people of Northern Ireland. Mary Harney sees real benefits for the people of the Irish Republic, and we are working together. I very much support the initiative, but there are also other issues.

Antrim Area Hospital is another key element; it needs a £60 million redevelopment. There is also the regional children's hospital in Belfast. Go and have a wander round that hospital and see the conditions in which we look after our children. The hospital itself is fantastic, and its staff, from consultants to nurses, provide a fabulous service, but go and have a look at the condition of the building. The theatres at Craigavon Area Hospital are another of my key needs. It is not a giant amount of money, but about £9 million is needed to keep Craigavon functioning.

Day theatres are also needed at Belfast City Hospital. The City Hospital has been open since 1978. A small number of theatres were included in the original build, and demand has long outstripped that. I referred only to acute hospitals. We are not talking huge bucks, but there are local hospitals in Omagh, Lagan Valley, Whiteabbey, Ballymena, Banbridge, and mid-Ulster. I am trying to balance all those projects. I am not just looking at Altnagelvin, but I was amazed when it and Desertcreat suddenly appeared in the Budget statement. That means that £90 million is available, but nobody tells me that that money is spare and that they are just going to run it. I explained that we do not have the revenue to run it. That is the situation.

We will be out of cancer capacity by 2016. My project was to extend the City Hospital, which buys us time, and to build a radiotherapy centre at Altnagelvin. That is where we are at. I have room for two more bunkers in the City Hospital, and then it is full. That would take us on a few years, but, at the same time, it is all one unit. There is much travel back and forth; some folks go up and down to Belfast for radiotherapy two or three times a week. That is not just the north-west; it goes right across from Coleraine. Altnagelvin will play a key role in that, so there are huge gains to be made. When talking about cancer and, potentially, lives being lost, I do not think of those as being huge sums of money, bearing in mind that the proposed spending on roads is £0·5 billion a year. We do not have the money for the Ulster Hospital ward block, but we have £0·5 billion a year to build roads. I do not understand the logic of that, but that is where we are.

The year one profile — finding £200 million — is grim stuff. That is unachievable as things stand. It is stomach churning. Getting us up in a progression step to £4·8 billion after year four and beyond will not solve anybody's problems. That is basically keeping the wolf from the door

in the meantime. The Health Service has to be addressed properly. The historic underfunding has to be addressed eventually, and we have to commit to the Health Service. That has not happened over the past four years. I have struggled with inadequate budgets over that time, and the situation will get worse.

The Chairperson:

We have had increased productivity from the Minister and his team. At what time do you have to go, Minister?

The Minister of Health, Social Services and Public Safety:

I am past that time.

The Chairperson:

Pól has one last question.

Mr Callaghan:

I have three questions, but I am happy for the Minister to come back in writing. It would be helpful if we had a profile of the 4,000 job losses that are in play. Obviously —

The Minister of Health, Social Services and Public Safety:

It is right across the system.

Mr Callaghan:

It would help if we knew the functions, locations, grades, and so on.

I am interested in what John said about cash efficiencies being identified in the threshold between the £5·4 billion and the £4·8 billion. It would be interesting if we could know what you had in mind as regards impact.

Mr Compton:

I am happy to provide that information.

Mr Callaghan:

My final query is about planned pressures. We currently have the swine flu issue, and we had the

winter freeze. What contingencies are in play, depending on the different quantums that are eventually allocated, for those issues to be taken care of? Are they in there at all?

The Minister of Health, Social Services and Public Safety:

I am happy to respond in due course. As you are aware, there were huge pressures on A&Es and fracture clinics because of the bad weather. Fracture clinics cleared all their lists just before Christmas and were then affected by the water shortage. The South Tyrone Hospital in Dungannon, for example, was off the air for several days. That hit us across the service, and staff had to cope. Technicians slept overnight in hospitals to keep the theatres going. The ventilators in the theatres intake air only down to –4°C, but the air was down to –10°C so the ventilators were freezing up and theatres were being lost. That is the type of commitment that we have. Nurses came in with overnight bags because they were not sure whether they would get home at the end of their shifts.

We then entered into the swine flu situation. There is a lot of hype about swine flu. The vaccination process started on 1 October, so we were pretty well through that. We now have a rush on that, but we are coping. There are adequate supplies. We are coping, and that is a testimony to the staff in the Health Service. It has been my privilege to have been the Health Service Minister for nearly four years and to have supported, as best I can, a workforce that makes huge daily sacrifices for all of us. As political representatives, we should do what the population wants us to do by giving it the support that it requires. I am not asking for anything other than the same sort of deal that was received in England, Scotland and Wales, and the money is there.

The Chairperson:

Thank you very much. We said that we would take an hour and five minutes; it was a bit longer than that, but that was very useful.