Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Draft Budget 2011-15: Department of Health, Social Services and Public Safety

20 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
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Mr Paul Girvan
Ms S Ramsey

Witnesses:

Mr John Cole	)	
Mr Paul Cummings	)	Department of Health, Social Services and Public Safety
Ms Catherine Daly	)	
Dr Andrew McCormick	)	

The Chairperson (Mr Wells):

We have a team of four representatives from the Department today. We were expecting only two, but a team of four is even better. Dr Andrew McCormick, the Department's permanent secretary, has a season ticket to the Committee having been here repeatedly; and Catherine Daly, who was

with us last week, is the acting under-secretary, resources and performance management. Perhaps the other two officials would introduce themselves for the record, as we do not yet have nameplates for them.

Mr Paul Cummings (Department of Health, Social Services and Public Safety):
I am Paul Cummings, director of finance of the Health and Social Care Board.

Mr John Cole (Department of Health, Social Services and Public Safety):
I am John Cole, the Department's deputy secretary and chief estates officer.

The Chairperson:
I knew your names, but I could not have made a stab at your titles — they are getting longer by the day.

The purpose of the session is to explore in further detail the information that was presented last week. On Tuesday, we had the benefit of hearing from two expert witnesses, who raised some extremely interesting issues. Professor Ciaran O'Neill from the National University of Ireland, Galway and Professor Charles Normand from Trinity College Dublin each gave a presentation to the Committee. I doubt that you have had the benefit of hearing what Professor Normand and Professor O'Neill said on Tuesday, but it really was fascinating, and some of what they said will be extremely relevant to this debate. We hope to get the Hansard report of that meeting as quickly as possible, because that will benefit us all. A great deal of information was thrown at us, and I think that you will want to peruse it.

We have set aside 45 minutes for this session. You are already aware of some of the issues on which we want clarification. I would like to put one of those issues to bed immediately: where do we stand with the monitoring round money? Why is there a difference of opinion between the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Finance and Personnel (DFP)? Are you getting the money, or are you not?

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):
DFP has not told us that we are getting the monitoring round money. There is no reference to it in the Executive's draft Budget papers nor in Sammy Wilson's statement. However, I defer to any information that you have secured from DFP. If DFP has told you that the money is there, I

am sure that that statement has authority. We have not been informed about that money, but we would be glad to find out about it this afternoon. Every little helps, as Tesco would say.

The Chairperson:

Yesterday, DFP told Colin Pidgeon, an Assembly researcher, that the money was not there. There seems to be a dichotomy between what officials are telling various folk. Immediately after the last meeting, we approached our DFP contact, who came straight back to say that we should not worry because the money was there. As you know, the monitoring round money was part of the deal to give flexibility to the Minister so that he does not have to seek approval to move money within his budget, which is a sensible arrangement.

Dr McCormick:

That deal was negotiated in January 2008 as part of the settlement for the 2008-09 to 2010-11 spending review. We did not assume that it carried forward, but if it does, it will help.

The Chairperson:

The research also shows that the brief of our —

Ms S Ramsey:

Sorry, Chair, but how will we find out formally about that money?

The Chairperson:

We have asked for that information. It was one of the questions that Pól raised last week.

Dr McCormick:

We will contact the DFP officials.

Ms S Ramsey:

If there is a difference between the thinking of officials in DFP and what the Minister says, we should get the information formally and in writing from the Minister.

The Chairperson:

Dr McCormick, I am sure that you listened with interest to Mr Pidgeon's comment that his research indicates a discrepancy between the allocations to the Health Service in England and that

in Northern Ireland, which is to the detriment of Northern Ireland.

This may be a difficult question, but let us assume, for the sake of argument, that the Minister's view is correct and that what Mr Pidgeon said backs him up. If the Minister of Finance and Personnel agrees that that is correct, acknowledges that it's a fair cop and that the discrepancy must be addressed, what would that mean in real terms for revenue funding for Northern Ireland next year?

Dr McCormick:

We have established what that would mean. The amounts required to bring us into line with the English settlement for health and social care area about £80 million in 2011-12, rising to about £160 million in 2014-15, which would mean a final recurrent total of approximately £4·8 billion for that year. In round numbers, the figures for each of the four years are £80 million, £100 million, £120 million and £160 million.

The Chairperson:

I gave you no prior warning of that question, so you must have anticipated it. It is very useful to have those figures. Could there be some misunderstanding? Should the comparison be not with the English Budget but with the overall settlement for the three devolved institutions? Would that change the figures?

Dr McCormick:

It is important to point out that Scotland has produced only a one-year Budget. Comparisons across all parts of the UK can focus only on the first year, because there is no information at all for Scotland for years 2, 3 and 4. That limits what can be done by way of comparison.

We have looked at the figures all ways up to try to understand all the different permutations. The settlement for health and social care in Wales is extremely challenging. However, the English and Scottish settlements are better than ours for year one. That has been established. The wider issue is what is viewed as the priority in the Northern Ireland context. We are happy to go into the various other aspects of the discussion that we prepared for this afternoon and to help the Committee with some of the points that were raised on Tuesday.

The Chairperson:

On Tuesday, Professor Normand commented on what the authorities in the Irish Republic had done. Admittedly, they were working from a much higher base and spending an absolute fortune on drugs. The authorities approached the drug companies and beat down the price. Professor Normand made the point that the vast bulk of the medical drugs for Northern Ireland are purchased by the Department, the Health and Social Care Board and the trusts. There are also a couple of private clinics, but they account for minimal purchasing. The Department, therefore, has a strong bargaining position. Given the economic situation, what is wrong with the Department telling the drug companies that it wants them to knock 10% or whatever off the bill? What sort of hard-nosed dealing is being done with the likes of GlaxoSmithKline and Wellcome?

Dr McCormick:

Paul will provide much more detail on that. As we work in a UK context, the use of the bargaining power of the UK Department is extremely important in securing the best possible deals. We have a programme that is designed to put as much downward pressure as possible on prescribing costs. We examine the nature of the drugs that are being prescribed and the way in which they are procured. All those elements of procurement are the subject of a strong cost-reduction programme.

The fact remains that the volume of activity is steadily rising as part of a pattern of greater need in the community. As people age, they acquire more long-term conditions, many of which require continuous access to medication. That is part of the nature of the service. Therefore, there has been steady growth in the volume of prescribing. The cost of prescribing is quite normal. Significantly, however, we have achieved a much greater proportion of generic prescribing, continued cost improvement and a quality-driven programme that secures outcomes for the patients. All those have been a major part of our work over the past three years. We received a strong boost from John Appleby's work in 2005, which gave added impetus to our ongoing work to increase generic prescribing. That involves the most hard-nosed negotiations possible with the drugs companies.

Mr Cummings:

We join the rest of the UK in ensuring that our considerable buying force is maximised. We drive hard bargains across all pharmaceutical expenditure. In the current year, we are on track to deliver £30 million of recurrent savings from that expenditure through the measures that Andrew

outlined. That represents significant savings from the start of this financial year, and those will be fed into the budget for the next financial year. We are well on top of that issue. The current figures indicate that we will achieve savings of £30 million this year.

The Chairperson:

On Tuesday, Professor Normand said that any organisation with your size of budget should be able to achieve between 5% and 8% efficiency savings each year. That does not mean that you are not efficient; it just means that you could be more efficient to the tune of between 5% and 8%. The Finance Minister is asking for considerably less than that. Professor Normand is a medical economist with 35 years' experience. What is your reaction to his statement?

Dr McCormick:

Over the past number of years, we have been conducting an extensive efficiency programme. The requirement to achieve 3% in savings a year was set in the 2007 comprehensive spending review (CSR). As Paul said, we deliver efficiencies in the pharmaceutical budget across a range of services. All trusts continue to seek efficiencies in their centralised management and in their local initiatives.

There is a continuous energy among clinicians to find better ways of doing things. That is what they are about. They do not need to be told to work on improvements. Clinicians and professional staff always seek better ways to provide services, many of which relate directly to improving efficiency. There is scope for improvement. It is important to emphasise that many of the improvements that are discussed relate to productivity, and such improvements must be pursued as much as possible.

Many of the improvements under discussion would produce a larger output for the same input, which means an improvement in productivity. Much of what we must concentrate on this time round, because of the way in which the budget is profiled, relates to cost reduction. I will use a crude example: rather than eight people performing 20 procedures, productivity could be improved if those eight people performed 25 procedures. That is great, but it does not reduce costs at all, because the cost of the eight people remains. Thus, this time round, we are trying to find a way in which six people can do what eight people now do. That is the challenge that we face in the present budget climate. Work can be done along those lines, and the service will do everything possible to deliver greater efficiencies, but that means job losses. The only way to

save cash is to have a reduced pay bill. We face a 1% reduction in real terms in 2011-12 and a higher than 2% real terms decrease over the four years. The only way to make real terms reductions, given the cost pressures that we set out earlier, is through a reduction in jobs.

The Chairperson:

Is that really the case? You have built in £78 million for increments. A reduction in the pay bill need not mean a reduction in the number of people being paid. How binding, or set in concrete, is the agreement that allows £78 million to be set aside for increments, given that that money could easily cover the cost of retaining staff whom you believe you may have to make redundant to balance the books?

Dr McCormick:

I will not disclose our legal advice, as it the convention not to do so. However, I will say that our clear understanding is that the increments are part of a contractual entitlement. At UK level, the advice from the Treasury last autumn was that the entitlement had to be honoured, and that is the basis on which all four UK Health Departments are proceeding. Before Christmas, NHS employers in England entered into negotiations with the staff side to ask whether there was a possibility of a deal whereby the unions would voluntarily agree to forego that contractual entitlement in exchange for a guarantee of no compulsory redundancies. A further meeting will take place in London next Tuesday.

The matter has been covered in the press, so there are no secrets. The unions have decided not to accept that offer. The principle of parity of pay across the public sector is very important from the point of view of planning and from the trade union perspective. The trade unions and management agree that maintaining broad parity on pay policy for health and social care and many other aspects of the public sector is extremely important. There is nothing that we can do separately about that matter. As far as we are concerned, £78 million, by the fourth year, is an inescapable cost, and the legal advice confirms that. The industrial relations position confirms that that cost remains. It is not easy to brush it away.

Ms S Ramsey:

The issue of parity is nonsense: it is used only when it suits. The negotiations are continuing in England, but we can make our own decisions here. Can we find out which local unions attended that meeting?

Dr McCormick:

Yes. Representatives from management side and the unions in Northern Ireland were at that meeting.

Ms S Ramsey:

It would be interesting to discover what the attitude of the local unions is towards saving jobs.

Dr McCormick:

We are well aware of the discussions. The trade unions at local and UK level were not happy to proceed with the deal. As I said last week, the deal was offered from an English perspective, and because the English settlement is, as we have established, more favourable, they were able to offer, in exchange for forgoing increments, a guarantee of no compulsory redundancies. We are not in a position to make the same offer because our settlement is not as good. That is the important difference.

We have held faithfully to pay parity in health and social care. The Agenda for Change programme and the consultant contract are honoured UK-wide. The pay review bodies, which deal with those annually, including the NHS pay review body and the doctors and dentists' review body, take evidence from the Department and the Northern Ireland unions. We are within the terms of reference of those pay review bodies, which have continually recommended sustaining a parity-based process, and that has been honoured.

Mrs O'Neill:

Thank you for coming to talk about these issues again. I want to pick up on the bid for demographic pressures and the extremely interesting argument that both professors put to us on Tuesday, which was about the proximity-to-death effect. Both health economists suggested that those bids could be more modest and that the pressure was being oversold. What are your initial views on that?

Dr McCormick:

Would that it were true. We would be glad to be proved wrong, because that would reduce costs and make things easier. However, we stand by our evidence and our view that the demographic bids that we lodged with DFP are well founded and are at the modest end of what we could have

asked for. Our approach to calculating the requirements is firmly and broadly in line with that taken in other jurisdictions, and the method is tried and tested. If we set aside inflation, it is possible to demonstrate that the historical pattern of the way in which costs have grown over many years reflects the demographic pressure. That has been established by a strong analysis of the evidence, and our bids are based on that.

It is important to distinguish between the costs of demographic pressure in different sectors. In the acute sector, cost is, undoubtedly, greatest at the end of life. However, a large part of the bid that we produced deals with the costs of social care, management in the community context and the management of long-term conditions. More people are living longer because more conditions can be managed rather than being fatal in the short term. However, the older one gets, the more long-term conditions one tends to acquire, and each condition adds to the cost. There are major costs to factor in. We are confident of our bids, because we feel that they are well founded and based on the evidence.

Mrs O'Neill:

What about the fact that people are ageing more healthily? That issue was also discussed on Tuesday. You may base your figures on past trends, but advances in technology, treatments, etc, naturally leads to people ageing more healthily. It is not good enough simply to dismiss that out of hand. You make the point that your figures are backed up by evidence, but where is your evidence? We do not have it.

Dr McCormick:

We are happy to provide more evidence.

Mr Cummings:

Unfortunately, we were not here for the presentations on Tuesday. However, from reading the two submissions, the inference seems to be that demographic pressure relates only to the programmes of care for the elderly and at the end of life, but it applies across all programmes of care. Take the example of a learning-disabled person who is cared for by elderly relatives, perhaps the mother and father. As the mother and father reach their 80s, substantial packages of care will need to be put in place.

Demographic pressure applies across all programmes of care. In obstetrics, there has been a

9% increase in the birth rate. Demographic pressure means real increases in volumes due to everyone living longer, not only the elderly. As people leave childhood, it becomes relevant to programmes of care in mental health, learning disability and physical disability. Thankfully, those people survive longer and no longer die as children. As they move out of children's programmes, they need packages of care to enable them to live full lives as physically disabled adults. That is where the demand comes from. Those people need increased acute care not only in the last years of their live but across the full range of care programmes.

Mrs O'Neill:

In your explanation of the bids, you said that older people cost the Health Service nine times more than someone of average age. How old is someone when they start to cost nine times more?

Ms S Ramsey:

Your age. *[Laughter.]*

Dr McCormick:

Those are broad estimates of the additional costs of the over 65s and over 85s. Those ages tend to be used to illustrate a point, but they do not apply to every individual. They are averages based on analysis of the empirical evidence. We are happy to provide more supporting detail about what underpins the calculation of our demography bid. It is built up using verifiable assumptions. The methodology has been scrutinised by our advisers, and it is line with the approach that is taken across the rest of the UK.

Mr Cummings:

We can provide you with the current costs for the over 65s and the over 85s. That is the basis on which the capitation formula is built. We can tell you our current expenditure on each age category. There is an age-cost profile of the current expenditure in Northern Ireland.

Mrs O'Neill:

Is the fact that people are ageing more healthily factored into that calculation?

Mr Cummings:

Yes, because that will reduce the spend. If, over time, people live without needing healthcare, spend on over 85s will reduce. If they need less healthcare, that would be factored in. It is driven

by numbers, and the biggest indicator is the rise in volume. We may spend less on each person, but the significant rise in the number of over 85s is what drives the overall increase in spend.

Mrs O'Neill:

I still would like to learn more about the argument on proximity to death that was put forward on Tuesday. It was extremely interesting, and the Committee should give it more consideration. I look forward to you providing more information to us.

I want to pick up on the figure of 4,000 job losses about which the Minister was scaremongering last week. Have you any more details for us this week? Last week, we asked for information on what grades may be affected, where the losses will be and for the calculations to back that up.

Dr McCormick:

Given our current stage of planning, that calculation is not based on input from the trusts or other organisations. The Department and the Health and Social Care Board made that calculation. It is possible to confirm it through a broad-brush calculation, but that is supported by some highly detailed analysis. We looked at the level of savings that we are required to make, the possible sources of savings between different aspects of service and the growing costs. The model that supports the calculation is quite complex. The calculation is absolutely not an attempt to scaremonger. It is rooted in a factual analysis of the implications of the draft Budget scenario as it stands. It is possible that it is an underestimate.

The Chairperson:

Are those compulsory redundancies or natural wastage?

Ms S Ramsey:

Where will the jobs be lost?

The Chairperson:

Some 1,500 posts are already frozen under natural wastage. Therefore, are we simply talking about not replacing people, or about sending them out the door?

Dr McCormick:

At this stage, we cannot be clear about the proportions of voluntary and compulsory redundancies, but we face the possibility, if the current draft Budget is confirmed, of 4,000 redundancies. A large number of posts have remained vacant in the current year because of the need to control cash in the 2010-11 financial year and because of the sudden reduction that arose through the budgetary process in the spring, when the Executive had to make reductions well ahead of the implications of the financial crisis. The required adjustment to the Northern Ireland Budget was on foot of the local issues that had arisen, notably the equal pay settlement and the water charge issue. Therefore, the trusts have experienced significant financial difficulties in absorbing their share of that reduction. We have to carry forward 1,500 posts, held vacant in the current year, because of that extremely tight position and because the turnover of health and social care staff in Northern Ireland has reduced. People who have a job are more inclined to stay in that job. In a normal, healthier economic situation, more people would be willing to move around the labour market. The position is that the rate of natural wastage has declined. The position is much tighter; hence we have a problem.

The broad-brush calculation is straightforward. There is a recurrent cost pressure of up to £800 million by the fourth year. We have to consider the difference between what we projected would be our ongoing normal costs and the amount of money that will potentially be available.

If we assume that £160 million will come directly from staff savings, at an average salary in the trusts and across the service of £40,000 per job, the number of redundancies calculated on that broad basis is 4,000. Both the broad-brush calculation and the detailed calculation come out at around that figure. Obviously, it is not precise. It is not built up grade by grade or organisation by organisation. In the weeks ahead, we will have to engage with the trusts to establish more fully what they need to plan for, but the broad picture is rooted in clear evidence. That is our advice to the Minister and it is the advice that we, as a team of officials, would give to any Health Minister. It has nothing to do with the Minister's taking a particular view or anything of that nature. That is our advice, based on factual analysis.

Mrs O'Neill:

If there is clear evidence and factual analysis, why do we not have it?

Dr McCormick:

We can provide you with more data.

Mrs O'Neill:

With respect, we asked for it last week, Andrew. You are back here this week and —

Dr McCormick:

I am sorry. Following receipt of your letter after last week's session, a draft is being prepared to provide you with more detail. It will go to the Minister shortly.

The Chairperson:

Indeed, Pól Callaghan tabled some specific questions that we asked to be answered in time for this session. However, as far as we can see, there is no sign of that information coming to us. I hope that you received that request. If the answers are coming, could they come quickly? The questions that Pól posed were extremely relevant.

Dr Deeny:

I have two questions, the first of which is about prescribing. I must declare an interest as a GP.

Ms S Ramsey:

Go on, Kieran.

Dr Deeny:

I am also a member of a local commissioning group (LCG).

Ms S Ramsey:

Negotiated in London.

Dr Deeny:

The LCG in the west is certainly starting to do business. I wish to point out to members that work is taking place on the ground to get practices to save money on prescriptions. For example, the 10 highest-prescribing practices in the west have been identified and spoken to, and they are now working to address the problem. Members also might not know about the development of primary care partnerships in which groups of practices are coming together. That also has the

potential to save a bit of money.

I was delighted to find out that, of 59 practices, our practice came top of the list for being the best at prescribing. I could not believe it, although I knew that we were doing the right thing. After that bit of self-praise, I want to make a suggestion to the Department, although it may have already thought about this. One issue that we discussed was the frustration experienced when another GP or I follow practice protocol and put a patient on a drug for, say, reducing cholesterol, but the patient is then put on a different, more expensive drug at a hospital, even though both drugs are equally effective. We need a hospital/community formulary so that practices and hospitals prescribe the same drugs. That is a serious situation. It is hard for GPs to say to patients, after they have been put on a different drug by a hospital consultant or heart specialist, that they are going back on the drug that the GP had prescribed. That is a discrepancy between secondary and primary care. Are you considering ways to address that?

Dr McCormick:

That is being worked on, and there are plans to produce a formulary.

Mr Cummings:

Joe Brogan, the chief pharmacist on the board, is working with medical directors from the five trusts to agree a common formulary that would apply to hospitals and the community. You are absolutely right that patients being prescribed something different by hospitals can lead to tensions and difficulties for general practices.

Dr Deeny:

Some patients might have received a two- or three-month supply of a drug from their GP practice, only to be given a different drug by the hospital.

My second question is about capital. I have to ask you this, particularly because John is here, and you will know why in a short while. The potential of moving revenue to capital has been talked about. Do you envisage that happening with the health budget? I had to ask that question, because that issue affects the hospital in Omagh.

The Chairperson:

I knew that that was coming.

Dr Deeny:

I remember John giving evidence at the Downshire Hospital. I have previously said to Andrew, since the budget was cut, that the people of Omagh have asked me many times about the promise that was made to them. They were told that if the political, public and elected representatives kept quiet about the argument over the acute hospital, they would get an enhanced hospital. Is that ministerial promise now gone?

The reason why I said "because John is here" is that I remember his visit to the wonderful Downe Hospital in my native town of Downpatrick, which he said cost some £64 million. My mother stayed in that hospital for a week, and she received wonderful care there. I remember saying to Andrew that the Department could save more than £100 million in capital by basing the Omagh hospital on the Downpatrick model instead of on a £190 million model. At the time, Andrew said that construction costs had gone down by 25%, which means that we are talking about it costing even less than £60 million. That would be one way to look after a population that feels betrayed and let down and to save the Department money. Psychiatric services were also promised for Omagh. However, even if you add those on, it would still cost far less than half the money that was to be allocated to Omagh. The population in Omagh would be happy with that.

Dr McCormick:

I will touch on the general point first, and John will come in more fully on the Omagh issue. As regards the transfer between capital and revenue, the position is, as Colin explained, that all the points there stand. The position arising from the Executive's consideration of the draft Budget is that Departments have the latitude, at their discretion, to transfer from revenue to capital and to seek the Executive's agreement to transfer from capital to revenue. The former option is subject to ministerial discretion, and the latter is subject to the Executive's discretion. As I explained, the reason for that is that DFP has to manage the totality. The Treasury restricts the total transferred, at a total level for Northern Ireland, between capital and revenue. It does not allow transfer at total level. If there has already been a switch in the Executive's Budget from revenue to capital, individual Departments have some scope to move some of that back.

We need to take account of all the Health Minister's considerations. We do not think that health has had a fair share of the capital allocations in totality. There were pictures in the newspapers yesterday of the Ulster Hospital at Dundonald. Recently, John arranged for me to

visit some of the premises in the health estate. The state and condition of many of the most important buildings in the health estate are not acceptable. Health Service personnel are providing the best service that they possibly can in what are quite appalling physical conditions. A responsible Executive and a responsible Assembly, to my mind and on my advice, would give a better priority to health estate buildings, because we face some very serious issues.

However, in the narrow, short-term view, if we are facing a situation in which, in the first year, we do not have sufficient revenue money to pay all staff — which, in fact, we do not — the temptation is there for the Health Minister to transfer as much from capital to revenue as the Executive are prepared to allow him to. He may make that case, which is still under consideration. Everyone is well aware of the Minister's commitment to sustaining jobs in the Health Service. From his point of view, that is very important.

A difficult set of decisions must be made. The need is demonstrable on the capital side. The list of projects that are needed stands strong comparison with those in other sectors. However, we also have a budget to balance. I am afraid that I am sharing a dilemma rather than offering a solution.

Dr Deeny:

Even a promise that a hospital will be built in Omagh two or three years down the line would be sufficient. We are not looking for it to be built next year. The Department has made a financial gain of more than £100 million, yet we were given a ministerial promise that if we kept quiet about the acute hospital, a hospital would be built on time. That is a major concern in my area, which is why I brought it up. You mentioned that construction costs had gone down by 25%. Based on that, I worked out that the cost would be less than £50 million.

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

Mr Cole:

I can give you figures to update the situation, Kieran.

Dr Deeny:

A hospital that would meet the needs of the people of Omagh and the health professionals would require much less money.

Mr Cole:

I will begin by giving you some more background information. We were setting all our development plans over the next four years according to the revised proposed allocation of capital under ISNI II. Members will know that capital takes a long time to deliver, and issues can run over Budget periods. Under ISNI II, we were provisionally allocated £1·342 billion for the next four years. In the current proposed Budget allocation, we are being offered £842 million for the same period. Therefore, in fact, we now have to achieve a £500 million saving in capital over the next four years out of that budget. That is an awful lot of capital. However, £252 million of the £842 million that has been allocated, which will sound like a lot of money to some people, has already been committed to schemes that are on site and proceeding. For example, £100 million has to be paid out when the hospital in Enniskillen completes.

The fact that capital pays for pandemic flu vaccines, IT equipment, ICT support systems and the maintenance of buildings is not recognised in our budget. From those, we have an annual oncost of approximately £395 million. When that is added to the contractually committed money, we are left with £195 million to start new projects over the four-year period.

Kieran, Omagh is an important project that we have in our sights and wish to do. However, there are many others: the Ulster Hospital redevelopment, the regional children's hospital, the Altnagelvin Area Hospital redevelopment, including the radiotherapy facility to which the Minister referred in his brief, the Antrim Area Hospital redevelopment, the Craigavon Area Hospital theatre redevelopment, the day theatres at Belfast City Hospital, a range of local hospitals, and a need for significant investment in mental health services. The Department is being forced to consider whether it should transfer some more of the £842 million from my capital budget to the revenue budget in order to prevent job losses. I can show you how that £195 million divides out over the four years. It pushes back by some considerable way many projects that we would have started earlier.

I want to reinforce Andrew's comment. Much capital money goes into other Departments. Some health facilities, which are the backbone of what society relies on and needs, are absolutely unfit for purpose. We know that, and we need to replace them. They include facilities to which you referred, but there is also the Royal Belfast Hospital for Sick Children, which needs investment, and psychiatric units that are past their sell-by date. We are trying to cover all those

with a very small budget compared with what we were originally promised. When compared with the allocations to other Departments, that does not show the allocation to health to be favourable.

We will plead for more capital. We are in a position whereby we might have to steal from the capital budget to maintain services and hospitals and to prevent redundancies. It is a shocking situation to look forward to. Until I know how much it has been agreed that I will get and what the profile of the budget will be, I cannot plan any major project. We are looking at a number of scenarios to see how we would manage that. No one would wish to undertake such a task, given the need and the supply of money to meet that need.

The Deputy Chairperson:
Alex, before you ask your questions, may I ask you to be brief? After this evidence session, we have a discussion on the draft Budget, which is followed by another evidence session. This is not a reflection on you, but may I ask you to come to your point rapidly? I ask the panel of witnesses to do likewise.

Mr Easton:
I had 11 questions, but I have cut that down to only eight.

We are considering the scope for transferring money from capital to revenue budgets. Can you tell me what the scope is for that? How many millions might you be able to transfer if you have to? How helpful is the additional £20 million that you may receive every year from the monitoring rounds? Earlier, you identified £211 million of extra funding from other sources in addition to the budget. Is there any potential for trying to get more from whatever sources they are? It would be helpful to the Committee to know what that extra income is.

As you know, Andrew, I think that you are a nice chap, but you are a bit aloof at times. It would be helpful if we could have an outline of the efficiencies that you are considering for the budget over the next four years. You mentioned drugs and the savings to be made in that area. I would like to know how much that is in millions of pounds. Can you break down that figure for us? I would also like to know how much we have in property assets that are surplus to requirements.

My last question is vital. You mentioned that the difference between our budget and England's is £80 million, but you were looking for £200 million last week. If we got the £80 million that England is getting, plus the £20 million from the monitoring rounds, would that be sufficient to get over the £200 million hurdle?

The Deputy Chairperson:

That is a long list of questions. May we have your best efforts to address them?

Dr McCormick:

I cannot give you a figure for the transfer of money from capital to revenue. It depends on how much headroom DFP has and what it allows other Departments to do. That will limit the scope. However, we are talking about a few tens of millions of pounds. The total solution will not come from that source. The £20 million a year from the monitoring rounds comes to the Department non-recurrently. It is only ever worth £20 million in any year. It would help, but it would not solve the big problem.

As came out in the Committee's discussion before we came to the table, some of the £211 million will be from transfers between organisations rather than additional income. Money from car-parking charges, for example, would be great, and we can consider that as a possible source. There may be some room for an increase, but the amount would not be vast. It is not as if hospitals will make a big profit from payment for services rendered by insurance companies or private activities. There may be an increase in activity, but that will not be a source of funding for public expenditure. It would be wrong to hold out that hope.

We will come back to you on efficiencies more fully. There are some major areas of work in which we are seeking to secure efficiency improvements, as highlighted in the Minister's paper. We are happy to come back with more detail on that. John may want to make a brief comment on property assets.

Closing the £80 million gap between us and England would be a major help. However, as I explained at last week's evidence session, the cash pressure that we face in 2011-12 is £200 million. Therefore, even if we got that £80 million, we would still be left with major issues. The £80 million would certainly take some of the rough edges off the problems, and it would be a good milestone on the way towards what would be a manageable settlement. However, it would

still leave us with significant problems.

Mr Cole:

We now have asset disposal strategies for all the trusts. We have gone through every property and lease that trusts hold and tried to release as much money as possible. We are looking at what happens when we sell those properties. Current estimates are that, if we sold those properties now, we would be virtually giving some of them away. The situation may have recovered in three or four years' time, when we may get more for those properties. We have to think carefully about that, otherwise we will be accused of being stupid in two or three years' time.

We look at this issue constantly. We are trying to rationalise our properties and get out of as many of them as possible. The fewer properties we hold, the lower our rates and maintenance bills. We are rationalising many of the old properties. I am happy to talk to you in depth at some point about our structured asset redevelopment plans.

Mr Cummings:

Alex, I will give you further clarification on income. Income is largely for services that we render. Private patients are one source, but the main source is nursing and residential homes that are run by the service. We charge according to people's ability to pay, and there are set agreed tariffs for all of those. We cannot make a profit in the Health Service; we can only recover the cost. As outlined in the Minister's draft Budget proposals, only new areas of co-payment will bridge the gap. All the money raised will go towards running the Health Service that we have today. It is all ploughed back into employing staff to run the Health Service.

(The Chairperson [Mr Wells] in the Chair)

Mr Gallagher:

I was looking at the earlier research paper on expenditure across the trusts. As you know, acute services take up the largest proportion of the cost, and the other services cost very much less. Indeed, not only are the largest costs at the acute services end, but they are increasing at a time when people do not stay in hospital much longer than two days unless they have a very serious condition. Kieran referred to local commissioning groups, and he knows more about those than I do. I understood that local commissioning groups and primary care partnerships were supposed to take the pressure off acute services. However, as I read the figures, there is absolutely no sign

of that. Is it the case that they are not working and need to be looked at again? What happened to that plan? There is no evidence of it working at all when the breakdown of the figures is considered.

Dr McCormick:

Demands are rising rapidly, and even with significant efforts by local commissioning groups and primary care partnerships, there will still be a trend of rising demand because of the needs of the population and the possibilities of what medicine can do. As new treatments emerge, more can be done. We had a long discussion on residual demand, of which I am giving a broad summary now. Demand will rise in any case. Even with the good efforts of fully fledged local commissioning groups and primary care partnerships, it would be wrong to expect acute demand to fall back. The fact is that it is still early days for them. LCGs came in, in their proper form, with the completion of the review of public administration on 1 April 2009. This is a long-term project, and they are still finding their feet. Primary care partnerships were launched in the autumn and are still in the pilot phase, so it is not as though they have had a long time to get going. Patience is required. It is the strong conviction of the management team and the Minister that this is the right thing to do. It is a matter of allowing it time to work and to secure better demand management.

Mr Cummings:

During the period to which the figures relate, we also invested significantly in the acute sector to improve access and reduce waiting times. Over that period, there has been a significant improvement in quality and access times, which is why the acute spend is increasing.

Mr Gallagher:

Even if it is a long-term —

The Chairperson:

Tommy, we have a problem. Dominic has been sitting outside for a considerable time. As he is your party colleague, I thought that I should intervene.

We will return to this discussion, but not today. The session has gone on longer than expected. I suggest that we let Dominic come in. The way in which we have treated him is ridiculous. He was meant to be giving evidence at 4.30 pm. We will have to address how we can

have a further discussion on this issue.

Mr Callaghan:

I would like to make a suggestion that might help us down the line, if the guys come back.

The Chairperson:

I do not think that they will be back, but we will have another meeting on the issue.

Mr Callaghan:

That reinforces my point. Much of our discussion is about the bids that have been provided to us in the table from the Minister. We have no comparable data about what the Department proposes to match against the bids from the allocation in the draft Budget. We are the last to make an appropriate comparative analysis.

Furthermore, there is a lack of detail in that type of table. "Demographics" does not tell us how much of the bid relates to paediatrics and how much to geriatrics. "Service reform and modernisation" gives very little data on the breakdown of service development. Generally, it would help to have much more information.

The Chairperson:

We must have anything that you can give us by Tuesday. We need answers to Pól's points. Michelle asked where any staff redundancies would come from. It is essential for the Committee to know what the Department is targeting.

Dr McCormick:

We will not have the detail on the breakdown of staff reductions, because that will depend on much more detailed work in the trusts, and that has not started yet. We can provide the Committee with the calculations that support our analysis.

The Chairperson:

We need that by Tuesday, and we may send additional written questions to the Department. I am sorry that we have had to curtail the meeting. All the other Committees will be home and having their tea by now, but this Committee is extremely busy.