COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

2010-11 Resource Spend and 2011-12 Budget

21 September 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Ms Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Michaela Boyle
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Mrs Pam Lewis
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

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

The Chairperson:
I welcome Ms Julie Thompson, the head of resources and performance management in the Department of Health, Social Services and Public Safety (DHSSPS), Mr Peter Toogood, the director of finance in the Department, and Mr Paul Gibson from the financial planning unit.

I want to divide the session into two sections. First, we will deal with the historical spend,

followed by a discussion on funding for the current year.

Ms Julie Thompson (Department of Health, Social Services and Public Safety):
Do you want me to talk about the historical spend position first?

The Chairperson:
We will discuss the historical spend, after which I will invite questions from members. We will then come back to the shortfall and take further questions.

Ms Thompson:
Thank you for the opportunity to provide evidence to the Committee for Health, Social Services and Public Safety. I will set the scene. It might be helpful to remind members that the DHSSPS looks after the largest budget, £4·4 billion, which is allocated across 17 health and social care and public safety organisations. As such, the Department's budget is complex, but I hope that I can help as we work through it. It may be helpful for members to have the departmental briefing paper to hand, and I appreciate the fact that you have just had access to it.

The programme of care analysis for 2010-11 is not due to be submitted by the trusts until October. Therefore, we cannot go through that data today. However, at appendix 1 of our briefing paper, we provide an analysis of planned expenditure by programme of care for 2009-2010 and 2010-11. You will note that the total planned expenditure increased by 2% between 2009-2010 and 2010-11. You will also note that the planned expenditure in mental health decreased by 1·3% between 2009-2010 and 2010-11, which reflects the significant reductions in service developments in 2010-11 that were required to meet the Executive's revised Budget allocations.

In appendix 2, we set out the comparative analysis of the budget, which is consistent with the information from the Assembly researcher. It shows the spend by each departmental arm's-length body, as well as family health services expenditure and the Department's budgets. Before we consider the variances, it is important that members acknowledge the fact that the Executive's final Budget for 2008-2011 provided the Department with financial flexibility. That is very different from other Departments and allows the transfer of resources across the budgets in order to address emerging pressures. In practice, that means that although initial budgets are established for each arm's-length body at the start of the financial year, those budgets will

increase or decrease throughout the year in response to service demands and budgetary management exercised by the Department.

I reassure members that such budgetary movements between and within the Department and its arm's-length bodies are tightly controlled and regularly monitored through the financial management regime. Performance against targets and objectives is managed through the commissioning plan and regular accountability meetings between the Department and its arm's-length bodies.

Appendix 2 shows that the Department recorded a total underspend against the 2010-11 budget of some £3·3 million. That represents less than 0·1% of the current expenditure for the Department and is in line with underspends of 0·1% and 0·4% for 2009-2010 and 2008-09 respectively. The budgetary control system, therefore, works in order to manage expenditure.

When we consider the variances between the initial planned budget and the actual out-turn, we see that the majority of arm's-length bodies' actual expenditure was broadly in line with the initial planned budget. In addition, all arm's-length bodies reported underspends at the end of the financial year. However, the Health and Social Care Board's actual expenditure is greater than its initial planned budget by some £78 million, while the Department's actual expenditure is less than its initial planned budget by £96 million. I will explain why those two variances are connected.

The Department endeavours to allocate the majority of its budgets as early as possible in the financial year, but in practice the Department holds back certain budgets and transfers them during the year to the Health and Social Care Board, which in turn transfers them to the trusts. That reduces the Department's initial planned budget during the year and increases the board's budget, which means that the budget is transferred to the organisation in which the expenditure will ultimately be spent. That effectively accounts for the reason why there are variances between the initial planned budget and the actual budget.

Perhaps some examples might help to explain this issue. In 2010-11, the budget transfers from the Department to the board for the supplement for undergraduate medical and dental education (SUMDE) were £36 million. That is the mechanism that we use to fund the additional costs associated with student teaching in clinical settings during undergraduate study. That

budget is not transferred out at the start of the year from the Department to the board, as the numbers of students are not finalised until later in the financial year.

Similarly, we transferred another £16 million to the board for other training issues such as post-registration nursing costs and allied health professionals (AHP) placement fees. Again, those were transferred during the year to meet the needs identified by the trusts. That also applies to the Business Services Organisation (BSO), which has an actual spend that is £15 million greater than its initial budget. The same principle applies to the transfer of resources during the year.

Appendix 2 also provides analysis of 2010-11 initial planned expenditure against actual expenditure by trust. All the trusts ultimately recorded small levels of underspend at the end of the financial year. The actual expenditure for 2010-11 exceeded the initial planned budget by £198 million. However, I again highlight the fact that the Health and Social Care Board is making allocations to the trusts and is holding some funding back for allocation during the year. For example, during 2010-11, trusts received funding for a range of service developments, demographic pressures, Agenda for Change and pharmaceutical pressures.

Actual expenditure on family health services amounted to £823 million, which is £29 million more than the initial planned budget. That is due to £10·9 million of out-of-hours expenditure being recorded only in the planned budget rather than in the actual budget, and it reflects the actual pharmacy savings that were achieved, as the Committee was previously advised.

In summary, the Department used virtually all its budget allocation for 2010-11 while endeavouring to ensure that funding was allocated to those organisations and for the services on which expenditure would be incurred. I am happy to take questions on that element of the briefing paper.

The Chairperson:

Thank you, Julie. One figure jumped out at us when the researcher presented his paper. The variance between planned expenditure and actual expenditure in 2009-2010 on health promotion and disease prevention was –52%. We asked the researcher whether that money was underspent or swiped. It would be helpful to have clarification on what happened to that money. We should be prioritising health promotion and disease prevention. The Minister says that nearly every time

I hear him speak. The money that is available for health promotion and disease prevention is much less than had been planned. Acute services still seem to be the black hole of the health service.

Appendix 1 shows planned expenditure by programme of care for 2009-2010 and 2010-11. The biggest increase in expenditure in those years was on acute services, which rose by 3·4%. It seems to me that, again, we are concentrating on fixing people when they get better as opposed to trying to keep them from needing fixing, for want of a better word. I spoke to someone recently about plastic surgery work and how it seemed to be changing. Obesity levels are climbing, and it is expected that a certain percentage of us will have gastric band surgery in the future. Plastic surgery will be required to deal with excess skin and other consequences of gastric band surgery and severe weight loss. It would seem to be far more sensible, practical and cheaper to work on ensuring that people do not get fat rather than planning for when they are fat. What would happen if the health promotion and disease prevention budget was swiped and money was not invested in sending out health promotion messages? I will wait for your answer with bated breath.

Breastfeeding comes under the health promotion programme. I am a huge advocate of that; I breastfed my three children, and I know about the benefits. Their eating patterns meant that they were not overweight when they were babies or toddlers. I have told the Committee previously that the child that I breastfed for the least amount of time is the one who is prone to carrying a wee bit of weight. I believe that the children got a good solid foundation and building blocks from being breastfed. I see those benefits all the time with my friends who breastfeed and when I attend the local breastfeeding support group. Why, then, are we not putting more money into ensuring that people are supported to give their children a solid basis?

Preventing obesity and promoting healthy living, diet and exercise and stopping smoking all come under health promotion, but it seems that the focus is still on surgeons getting at you to strap you up and tie you up and do whatever they have to do, such as putting in a gastric band or taking two stone of skin off someone who has lost weight. Why are we not spending more money on health promotion and planning a future that does not include 30% of us being morbidly obese?

Ms Thompson:

I will deal with the financial side of the equation. Table 3 in the researcher's briefing note shows the difference between actual expenditure and planned expenditure. The bases for those two analyses are entirely different, thus making comparisons very difficult. To a certain extent, the variances that you are looking at are not —

The Chairperson:

Sorry to interrupt, Julie. That briefing note states that the source is:

> "RaISe calculations based on DHSSPS data."

Ms Thompson:

It is our data, but we would never put them beside each other in the way that the research briefing note does.

The Chairperson:

I am sure that you would not.

Ms Thompson:

I need to explain why, because this applies to every programme of care that is listed in the researcher's table. The figures on actual expenditure are provided to the Department by the trusts. They include non-recurrent and recurrent expenditure and reflect the entire expenditure of the trusts during that financial year. It is a cast-iron figure that relates to their accounts and shows their actual expenditure in the financial year. It also shows the total expenditure, so when a trust receives income from client contributions, residential homes or other income, the figures reflect that trust's gross expenditure from its accounts.

The figures on planned expenditure are used as a planning document. Again, they are provided by the Department and are in the strategic resources framework. That document looks at trends over the future and includes only recurrent money, so any additionality that goes out to the system during the year is not reflected in the figures for planned expenditure. Another key distinction is that, if the board were to allocate money that is not to be spent by trusts, perhaps because it is regional in nature, it would still be included in the planned expenditure figures but not in the actual expenditure figures that are recorded by the trusts.

Therefore, the comparisons between planned and actual expenditure are not meaningful because they are not like for like. I will deal with the Chairperson's question. The planned and actual expenditure of the trust element of the health promotion and disease prevention programme are pretty much in line at £47 million and £46·9 million respectively. The picture is distorted by the fact that other moneys are brought in that do not go to trusts and are allocated to other organisations by the board. That is why, with every programme, the analysis presented side by side in that way does not compare like with like.

The Chairperson:
Do you not produce plans to implement policies? Surely we need to have a plan and stick to it to recognise the Minister's priorities. Ultimately, you are supposed to take the Minister's guidance. I must be very cynical, or perhaps I am just grumpy, but the phrase "lies, damned lies and statistics" is going through my head. If table 3 in the research briefing note is misleading, I would have appreciated if it you had come with a table that puts that right and explains the difference. The Committee is not being given access to the figures on the difficulties on spending in the Department that we need to help the Minister and the Department to make the right decisions.

Mr McCarthy:
I want to carry on from what the Chair said, because I raised that very point last week. In 2009-2010, £9 million was meant to be spent on mental health but was not. What is the reason for that? That is £9 million less spent on mental health.

Ms Thompson:
The Department uses the planned expenditure line to look at trends over time. We look at the recurrent position year by year, in 2009-2010, 2010-11 and 2011-12. As the Chair pointed out, we look at where that expenditure is going, whether it is in line with strategy and whether it is going in the right direction. I accept what the Chair said about the need to invest in health promotion, and a shift to the left is the philosophy of the Department. Unfortunately, that means that when actual expenditure and planned expenditure are put together in the way that the researcher's table does, the variances are not the reality of the position. We look at planned expenditure as a trend and, equally, actual expenditure as a separate trend. We would never put those two together.

In budgetary control and financial management, we have a strong system with the board and all our arm's-length bodies around the moneys they receive, where they are spending against budgets and how they are getting on with that. That translates into the Department's ongoing very low underspends in recent years. That is the mechanism by which we track that information.

The programme of care analysis is done as a one-off at the end of the year and a one-off at the start of the year. Therefore, that looks at longer-term trends, which I think is what the Chair was saying. It is about those longer-term trends and whether planned spend, year by year by year, is going in the right direction.

As a separate analysis, we look at actual spend and where it is going year by year. The two are done on different bases. Therefore, that £9 million is not a meaningful variance between the two years.

Mr McCarthy:
I hear what you are saying, and I have to accept that.

The Chairperson:
You look as convinced as I do. *[Laughter.]*

Mr McCarthy:
I am sure that the people involved in mental health would want to ask a lot of questions. They could spend £9 million if they could get their hands on it.

Mr Durkan:
Supplementary to Kieran's question, I have a question based on the perceived variance as we read it — I do not think that we can read it any other way — in underspend last year. Planned expenditure for this year is a reduction on planned expenditure last year. In the area of mental health, which is, I have been led to believe, a ministerial priority, I find that hard to understand. I wonder whether the planned expenditure this year is based more on the actual expenditure last year rather than the planned expenditure last year. *[Laughter.]*

Ms Thompson:
I am with you. *[Laughter.]*

Mr Durkan:

If less was spent last year than intended, is that being reflected in the planned expenditure for this year?

Ms Thompson:

Yes it will be, to a certain extent, because the planned expenditure for any given year will bear a relationship to what happened in the previous year. You are right to say that mental health expenditure dropped by £3 million between 2009-2010 and 2010-11, as is shown in appendix 1 of our briefing paper. A significant service development in mental health was intended in 2010-11, which, ultimately, did not happen because of budget cuts applied during that year. That is why expenditure dropped, because the trusts were also making efficiencies at the same time.

There is certainly a relationship between actual and planned expenditure, but we do not put the two beside each other. The table in appendix 1, which shows planned expenditure for each year, would be the way in which we make a meaningful comparison year on year.

The Chairperson:

The fact that you said that there is a relationship between what was spent last year and what is planned for this year worries me. Mental health was badly cut. Does that mean that the basis from which we will be starting in future years will be from where the cut happened? It seems that decision-making has been based on acute services being increased on the back of mental health priorities. Acute services get more money, so they will start on a higher basis next year and can continue to ask for whatever they want. Jim, I hope that you are listening because it is very clear that the ministerial priorities are much —

Mr Wells:

I am listening to every word of it, Chairperson.

The Chairperson:

— further down the list of priorities than people would like them to be. Will you assure the Committee that, during 2009-2010, the public health budget was not raided for money to cover shortfalls in other areas? That was not clear from your answer.

Ms Thompson:

The planned money and the actual money in the public health budget in 2009-2010 were pretty much in line. The £50 million-odd that is missing, which is referred to as "variance" in table 3 of the research briefing note, is effectively money that was spent outwith the trusts by the board. It is still there and was still spent, but it has not been reflected in the trusts' expenditure. The trusts' expenditure was exactly in line.

Mr Wells:

Once again, it seems that the Southern Health and Social Care Trust is the trust that was closest to meeting its targets. Has there been any significant variation among the trusts? The variance figures indicate that some trusts may have needed to be rescued in the middle of the financial year, so they just had a bit of extra money pumped in so that they did not look so bad. It may be that the trusts were relatively close together in how they performed, but the Southern Trust seems to have been the trust that performed best. Is that a correct reading of the facts?

Ms Thompson:

The Southern Trust was closest to its initial planned expenditure. That is based on less money being transferred to it during the year. You are right about how we manage the trusts: each trust is in a different financial position, but we monitor them very closely through the Health and Social Care Board. It monitors the trusts directly and then reports that position to us. The Southern Trust had the biggest underspend, but those figures are very small. There is not much to be said about that. Normally, its financial position would be reported to us regularly in the financial balance.

Mr Wells:

So are there lessons to be learned for the other four trusts?

Ms Thompson:

When financial positions are being monitored across all organisations, that information is shared across all the trusts. The ongoing performance and efficiency delivery unit (PEDU) review has been examining where savings are being identified and whether opportunities or actions are being taken across trusts in a similar vein. The trusts need to learn from one another; if actions are being put in place in one trust, the other trusts need to ensure that, where appropriate, they are put in place also. That has been the ethos behind the PEDU review.

Mr Wells:

How do you explain the Ambulance Service situation? It is completely out of kilter with everything else.

Ms Thompson:

I may need to come back to you on that. I am not sure. Obviously, the Ambulance Service received more money at the start than it ended up with, but I am not quite sure what the reduction was. We can come back to the Committee on that.

The Chairperson:

Members are trying to digest this information because they did not get it early enough. Appendix 1 of your briefing paper shows that there was a clear financial cut in mental health from 2009-2010 to 2010-11 and a significant increase in acute services. I welcome the increase in elderly care; I do not think that any of us would disagree with that. However, the decrease for mental health is worrying, as is the big decrease in primary health. When will we get the figures based on Edwin's priorities? Presumably, these ministerial priorities were set before Edwin came into office, so when do we get his priorities? When will we get any kind of assessment by PEDU?

Ms Thompson:

I will answer the second question first. The interim PEDU report is due in line with October monitoring. The outworkings of the 2011-12 financial year will not be available until this time next year. Many of the new Minister's priorities and where expenditure is incurred during the year are based substantially on material that was already in train, and it is on that material that we will start to see trends coming through.

The Chairperson:

We are halfway through the —

Ms Thompson:

The new Minister is setting the commissioning direction for the board and the trusts to give them an idea of what he expects to happen. I know that the Committee has already discussed that. That is already in play with the organisations. The outworkings — the actual expenditure for 2011-12 — will be reported this time next year.

The Chairperson:

We need to see the plan rather than the action. We need to know the basis and the template on which you are working. The planned expenditure table shows primary health and adult community expenditure being cut by nearly 3% while acute services are to be increased by 3·4%. I wonder whether the Minister has been apprised of those figures. Are they in line with his thinking? They sound like nothing that we have heard from him. It worries me that there may be one plan for the Department and another for the Minister that does not advise him of the extent of the difficulties in some areas.

I do not mean PEDU to be a side issue, but I want to question the fact that PEDU is likely to produce an interim report in time for the October monitoring. We understand that the Minister is looking at areas for which he may bid for funding through the October monitoring. Can you give us any information about the bids that are likely to be made? We have a strong view on the bids that the Minister should have made in the last monitoring round but which he did not make.

Ms Thompson:

The Minister is still considering what bids he will make. He stated his opinion publicly on the drugs issue earlier this week and again today. We have not yet reached the point at which I could talk about October monitoring in any detail. I am happy to talk more about the 2011-12 financial position when we discuss that element of the agenda.

The Chairperson:

I should not have put those two questions together, as I have given you a chance to wriggle out of answering the first one about whether the Minister knows about the planned expenditure and whether it meets his priorities. It does not seem to.

Ms Thompson:

The planned expenditure for 2011-12 is not ready; it is being finalised. When it has been finalised, it will be with the Minister. We expect it to be ready shortly.

The Chairperson:

When will we see it?

Ms Thompson:

You will see it when it is published and made available.

The Chairperson:

It will be available to us when it is available to the public. Will we not get it in advance? Whether we like it or not, our job is to scrutinise the figures, and we cannot scrutinise figures that we do not have. We need the information as early as possible.

Mr Durkan:

Will the plan be based on this year's actual expenditure?

Ms Thompson:

The plan for 2011-12 will be based on what is planned to happen during 2011-12 and where resources are planned to be allocated by programme of care. It will be across the health and social care sector and will relate to ongoing recurrent expenditure invested in the service. It will be on the same basis as the planned expenditure for 2009-2010 and 2010-11.

Mr Durkan:

Will it also reflect the Minister's priorities?

Ms Thompson:

Yes, to the extent that it has to reflect the commissioning direction that the Minister has set.

Mr McCarthy:

I want to ask the witnesses about a different issue. Your briefing paper refers to the Northern Ireland Fire and Rescue Service budget for 2011-12 being reduced. By how much exactly will it be reduced? Are you confident that the —

The Chairperson:

Sorry to break your stride, Kieran, but that is the subject of the second part of the evidence session. We will get a presentation on that.

Mr McCarthy:

I will keep that question for the second part, then.

Mr Wells:

I observe, Madam Chairman, that it is 21 September, and we are getting the budget for 2011-12 when almost half the financial year is gone. What possible input do we have in that situation, given the fact that half of it is spent and that we cannot turn the tanker round at this late stage of the year? I have made the point several times that we must never allow ourselves to be in this position again. I know that the election was the reason, but we know when elections are to be held; they do not come up and bite us. We must make absolutely certain that we do this in the right way, which is not in September.

Ms Thompson:

The commissioning side's guarantees and promises on that are to make sure that those planning documents are available in advance of the financial year, and that was discussed in Committee in July.

The Chairperson:

So can we tie you down to a date for the next set of plans?

Ms Thompson:

I will come back to you, if possible, with the date. I will need to clarify how far away that is, but I do not think that we are that far from getting you the 2011-12 plans. They should be with you very shortly.

The Chairperson:

This side of Christmas, do you think?

Ms Thompson:

Oh yes, in the next few weeks.

The Chairperson:

Will it be in October, this side of Halloween?

Ms Thompson:

Yes, absolutely. *[Laughter.]* I thought that you wanted to know whether it would be this week or

the week after.

The Chairperson:

We need to see those figures as soon as the papers are ready. We accept the fact that the Minister is the Minister and that he will get them first, but I expect us to get them very shortly after him in their full glory, without redaction. This situation is not acceptable; we cannot do our job with the information that we are getting. The fact is that, at this stage, Edwin will be halfway through his term before any of his priorities are actioned.

Mr Dunne:

I come back to the Chairman's first point, and I will refer to our research briefing note. Some of us are still unclear on the issue of health promotion and disease prevention. I accept your point that it is probably not good practice to show the actual against the planned expenditure. Will you explain what your briefing paper means in relation to "DHSSPS — Education and Training"? Is that the same budget as health promotion and disease prevention?

Ms Thompson:

No. Health promotion and disease prevention refers to promotional activities within the trusts. Education and training budgets in the Department are more about training doctors and nurses, and so on, across the system. That is the budget for those. They are completely different budgets.

Mr Dunne:

So how does this come in? I know that the research briefing note is probably not in line with all your processes, but how do you explain that in your paper?

Ms Thompson:

Appendix 1 of our paper sets out planned expenditure by programme of care analysis across the years. If we compare the researcher's table on actual expenditure across the years with our table at appendix 2, we are happy with our analysis.

Mr Dunne:

So appendix 1 shows that health promotion spending went from £94 million in 2009-2010 to £93 million in 2010-11.

Ms Thompson:

That is correct.

Mr Dunne:

So are the figures in this research briefing note not strictly correct historically? We got this information last week. We went away, reviewed it and talked about it. We thought that those were the figures that we would be challenging here today, but, strictly speaking, they are not correct.

Ms Thompson:

There is some analysis of expenditure that was not by programme of care that has been missed off the actual figure work. So the planned expenditure in table 3 of the research briefing note adds up £2·9 billion rather than £2·8 billion. At the bottom of appendix 1 in our paper, we have explained that there is a mismatch.

Mr Dunne:

Yes; I understand that.

Ms Thompson:

So that is where that has come from. Depending on when the question is asked, there can also be differences in where we are at in a particular financial year, and we try to keep the figure work as up to date as we can.

The Chairperson:

We assume, Julie, that you would want to keep the figures up to date as much as possible for your own benefit as for the benefit of any of us. However, it is a bit worrying that Colin from Research and Information Service (RaISe) has put this paper together for us based on your figures. The fact that you are suggesting that his figures may not be accurate or that he did not have the information to base it properly on planned versus actual expenditure does not fill any of us with confidence. I do not want his credibility to be questioned in any way. If the whole accounting ethos in the Department is such a hames that a researcher can make neither head nor tail of it, it is not a good place to be, is it, especially when you think about the size of the Department's budget, which is in the region of £4 billion? Every single Department is getting cut, and we are living in a serious financial climate. At the same time, the front line seems to be

taking considerably more of the hit than we would want it to. We need to see investment in mental health, elderly services and health promotion, and, whether it is my natural cynicism, it seems that acute services is the big thing to be protected in the Department, while the rest is secondary.

I have no doubt that Colin has done a good job in providing us with the figures. However, if there is such a morass in the Department that he is getting figures that you are refuting, that is hardly good enough. I expect the Committee to be given clear figures in tabular form, or whatever, that are easy to understand. There should be no room for discrepancies, such as "That was actual, but it was not actually spent", or "That was planned, but we did not get around to it", or whatever. It is difficult to scrutinise budgets in that climate. If poor Colin is watching, God love him, for he will be mortified. However, I have no doubt of his credibility and the job that he has done. I am disappointed that our information does not seem to tally with what we got from him. We can all be cynical, but it is a difficult format in which to do our work.

Does anybody else want to comment or ask questions before we move on to the next presentation? You are all very quiet today, members. It is not like you.

Julie, is it you or Paul who will deliver the next presentation? Are you getting a break now or is it back to you?

Ms Thompson:

It is still me.

The Chairperson:

If we can have the presentation on the proposals for meeting the budget shortfall in 2011-12, Julie, we would appreciate it. For members' information, the papers are in your packs.

Ms Thompson:

I will speak first about the position for current spend in 2011-12. As the paper sets out, our current assessment is that the extent of the unresolved funding gap has improved from that previously reported to the Committee in June. Before I explain the movement of the June position, it might be useful to recap briefly on the financial position that was previously reported to the Committee.

On 29 June, Dr McCormick advised that the unresolved gap for 2011-12 amounted to £72 million. I remind members that, in reaching that unresolved deficit of £72 million, it was assumed that the trusts would contain their recurrent deficits of approximately £79 million in order to achieve break-even.

I should stress that the financial climate for 2011-12 remains exceptionally challenging. However, there has been an improvement in our financial position, and our current assessment is that the unresolved gap is likely to be less than £15 million. We are working hard to remain within the financial resources available. That is attributable to a number of robust interventions taken by the Minister, the Department and the Health and Social Care Board. As is highlighted in the briefing paper at tab B, the reduction is primarily due to two factors: constraining the extent of funding allocated to meet residual demand and interventions to constrain expenditure. I wish to talk about each of those measures in turn.

First, residual demand relates to the financial pressures that arise from the service developments and technological advances that should be funded to maintain parity of treatment with the rest of the UK. However, in the light of the constrained financial climate, we have been left with no option but to manage the pressure downwards to the available budget. By way of context, the unresolved funding gap of £72 million that was reported to the Committee in June assumed that some £60 million of residual demand would be met during the year. However, it has been necessary to revise that downwards to £15 million.

What does that mean? In simple terms, it means that, as a result of budgetary pressures, health and social care in Northern Ireland is not able to provide certain services, or patients are required to wait longer to receive services. That is an extremely concerning situation. The reduced access to treatment and care for patients and clients in Northern Ireland creates a divergence in the quality of provision compared with that in the rest of the UK.

The Minister outlined two such difficulties in questions for oral answer earlier this week: fertility treatment and specialist drugs. Those are only two examples across a wide spectrum of services for which service needs cannot be fully met. As the Minister advised on Monday, his current intention is to bid in the forthcoming monitoring round, given that any divergence from Northern Ireland's ability to match NHS standards and principles must be taken very seriously by

the Executive and the Assembly. That approach will be informed by the outworkings of the ongoing PEDU review.

On the second factor, we have implemented a range of measures to constrain expenditure across the entire budget. We have sought to explore all possible opportunities to deliver further efficiencies, and we outlined three key areas in the briefing paper relating to the trusts and the board. First, as payroll costs represent the majority of expenditure across the budget, the board has been investigating all possible options to minimise the funding required in that area. It has completed a detailed payroll expenditure review, which examined pay growth requirements and took into account the actual headcount, grading and the latest projections of staff turnover. Savings have been derived as a result of that exercise, but I can assure the Committee that all staff will be paid in line with contractual commitments.

Secondly, in addition to the trusts' requirement to break even in 2011-12, the Department has asked for further savings to be delivered from the board's allocation. Finally, the board has identified a number of service areas in which expenditure can be deferred until 2012-13 without there being any long-term impact on patient care. Those areas are planned to generate savings of some £30 million from the board and the trusts. In addition to those areas, we are continuing to explore all other potential opportunities to manage expenditure, such as controlling the level of overspend in the general dental services budget for the future. We will keep the Committee informed of that as proposals are developed in due course.

We have also examined where additional savings can be delivered from the Department's smaller arm's-length bodies. For example, in addition to the measures that we highlighted to the Committee in June, there has been a reduction to the Fire and Rescue Service budget, based on historical spending patterns and known commitments in 2011-12.

Taking all that into account, our current assessment, as I said earlier, is that the unresolved funding gap is likely to be less than £15 million, and we are working hard to live within the resources available. However, I should stress that we are less than halfway into the financial year, and, given the complexity of the budget and in that context, the assessment may be subject to further change as the year progresses, particularly in a number of volatile areas. Although the financial assessment has improved, through a range of robust interventions, that cannot be separated from the real and concerning implications for patients and clients over the level of

services provided. The Minister will be considering that issue further as we approach the October monitoring round.

The Committee should also be aware that the financial and service challenges for the future years remain serious. In that context, the planning process for those years is under way. That will be informed by the emerging findings of the health and social care review, which is being led by John Compton and is due to report in November, and the ongoing PEDU review.

I am happy to take any questions.

The Chairperson:

Thank you, Julie. I noted with interest that you said that pay would be done in line with contractual commitments. That will certainly be welcome, because we heard very clearly from the Royal College of Nursing (RCN) that it would not accept any change to its contractual commitments. Does that mean that previous pay predictions were wrong? Were trusts perhaps overstating their pay costs deliberately to ensure that they had enough money to run their service?

Can you give us a position on redundancies? We have had a couple of years of natural wastage, and it has created a huge number of problems for front line staff, who are working under severe pressure. Does that mean that the position on natural wastage will be reversed? Do we need to continue down that route?

Ms Thompson:

The initial analysis of the pay issue is done at a relatively high level. It then needs to be worked down through the individual organisations to assess what is genuinely needed for pay growth. That has resulted in the production of the savings that are being talked about today. It has been done through a very detailed analysis, person by person on the pay bill, to make sure that what is given out is what is required. Yes, it is lower than what would have previously been assessed as being required.

The Chairperson:

Can you give us a reason why?

Ms Thompson:

Part of the element was the 1% increase in National Insurance contributions, which was factored in at a relatively high level across the piece. The rules change on National Insurance contributions depends on what a person is paid. That was, therefore, recalculated by trusts and was based on actual payments to individual staff, and that resulted in a reduction against requirements. The initial analysis, by its nature, has to be done at a very high level. That is now being dropped right down to every individual person so that the employer's National Insurance contribution element is the right one on the pay bill. That is reflected in the savings that are here now.

The Chairperson:

Is this the first time that that has happened? It is not something that would be a recurring trend, so it is something for which you would be prepared. Were you able to get at least a ballpark figure?

Ms Thompson:

The National Insurance contributions change was a particularly different one. A change of that scale does not happen every single year. We have certainly scrutinised to make sure that what is going out from the board to the trusts is what is necessary. That was certainly gone over in a very robust fashion to ensure that what is given out is the amount that is required.

The Chairperson:

What about natural wastage?

Ms Thompson:

The trusts have been asked in 2011-12 to come into recurrent balance, which means that they have to ensure that they can manage recurrently within their resources. It is about having the right staff on the ground and being able to provide services. The trusts have to ensure that, by the end of 2011-12, they can sustain their services recurrently. That is what is required of them in the 2011-12 year. In 2010-11, extra controls were put into trusts. Some of them were non-recurrent in nature, so the trusts were asked to make those recurrent during the 2011-12 year and to ensure that they can live within their current resources to give them a better platform to move forward into 2012-13.

The Chairperson:

Does that mean that the recruitment freeze is lifted?

Ms Thompson:

The trusts and the board need to comment on that, because it will all be based on workforce planning in the individual organisations. My sense is that the financial challenges are still there as we look forward, so they will be an issue for individual organisations and how they manage within their resources. Workforce is obviously a considerable element of the budget.

The Chairperson:

I will bring in Kieran on the Fire and Rescue Service issue that he raised earlier.

Mr McCarthy:

It says in your paper that the Fire and Rescue Service budget has been reduced. You do not say exactly how much it will be reduced by, but is the Department confident that that very important service will have the facilities to do the job that it is there to do?

Ms Thompson:

The reduction is £3 million. That reduction has been applied, but, given that it is such a demand-led budget, it comes with the assurance that the Department will look to see what it can do about any major, unexpected events or exceptional circumstances that occur. At the moment, however, what has been reflected is a £3 million reduction in that budget.

Mr McCarthy:

Will that mean reducing staffing levels or the service not being able to purchase essential equipment because of constraints on its budget?

Ms Thompson:

We have looked at the expenditure trend, which shows where the service has been historically. The trend indicates where it is likely to be, based on actual spend on the ground. Again, I apply the caveat that, should that not be sufficient in exceptional circumstances, further budget resources will be transferred to the Fire and Rescue Service. In that respect, it is about managing the financial pressures across the entire system, and the Fire and Rescue Service could not be exempted from that as we look at the budgets and how we can manage them. That is the basis for

the decision.

The Chairperson:

I absolutely agree with that. If there are cuts across the Department, the Fire and Rescue Service must take its pain as well. We are lucky, in that the Committee is not very Belfast-centric. We represent a broad range of constituencies across the North. I am anxious to stress that Kieran's point about retaining stations and staff, particularly in rural areas, is key to this. Clearly, there are ways in which to cut the Fire and Rescue Service's budget without affecting front line services. It may be that some of the non-essential expenditure that we have seen over past decades could be concentrated on to find those savings, while retaining firefighters. We have no sacred cows. The service will need to tighten its belt the same as everyone else, but we need to ensure that front line services are not affected.

Mr Wells:

I watch the Committee Clerk and you carefully, Chairperson, as I ask this question, and I will shut up instantly if either of you raises your eyebrows. On the issue of pharmacy efficiencies, am I right in thinking that that £30 million, which seems to tally with the figure that is taken out of the payments to pharmacists, is the issue?

Ms Thompson:

No.

Mr Wells:

So where is that?

Ms Thompson:

The pharmacy savings of £30 million was discussed with the Committee. Dr Norman Morrow was here in June to discuss in full detail the drugs bill and all the things that go with that. The community pharmacy remuneration issue, which is, I think, what you —

The Chairperson:

We are not allowed to talk about that.

Ms Thompson:

Exactly. I was about to stop.

Mr Wells:

That was my point. I am not going to go any further.

Ms Thompson:

They are not the same, and —

Mr Wells:

Well, where is that saving in the budget?

Ms Thompson:

You then get into whether there is a cut to that budget, and that is where I need to stop.

Mr Wells:

Yes. I thought that that would happen. We cannot go any further than that.

The Chairperson:

Is that generic drugs, Julie? If it is not related to the remuneration issue, we would like to talk about it.

Ms Thompson:

The £30 million identified in the paper is around generic drugs and was subject to a considerable amount of discussion in Committee on 29 June, when Dr Morrow was here. That pharmacy saving around generics was part of the whole discussion at that stage, when the relevant papers were provided to the Committee. That figure has not changed. It is exactly the same amount of money, and it is not to be confused with the community pharmacy remuneration issue.

Mr Wells:

The fact that £30 million is quoted in both is merely coincidental?

Ms Thompson:

Yes.

Mr Wells:

I will move on to the issue of residual demand. Are you saying that, in certain fields, Northern Ireland patients will receive an inferior service to those in England, Scotland and Wales because the Department has decided not to upgrade us in line with developments in the rest of the UK?

Ms Thompson:

We are saying that, to live within the financial envelope given to the Department, all the services that you might expect to be in place cannot be put in place, and, in recent days, the Minister has talked about some of those, particularly specialist drugs. As we look at the budget, that stance reflects the financial position. Therefore, we can manage the financial position, but the issue is then the implication of that for patients' ongoing access to services.

Mr Wells:

We could have a patient in Bedford and a patient in Belfast, but one of them gets an inferior standard of treatment for the same condition.

Ms Thompson:

That is what the Minister has been talking about, particularly the specialist drugs issue, which he intends to address in the October monitoring round.

Mr Wells:

However, as things stand, they are getting less treatment?

Ms Thompson:

That would be the case in certain areas, yes.

Mr Wells:

It is important that folk know that.

On other issues, I understand that the efficiencies were split so that the five trusts and the Fire and Rescue Service had to find something like £120 million and the rest was to be found by the Department. Is that roughly right?

Ms Thompson:

It sounds right. I do not have the numbers to hand. You are going for a figure of £177 million, but I have not got the split of that.

Mr Wells:

The bulk of it is being met by the boards. Is that fair enough?

Ms Thompson:

Yes, by the board and the trusts.

Mr Wells:

Is somebody keeping an eye on the boards to see whether what you are suggesting could be delivered is actually happening? We are half way through the year, so you should have a very good idea of how things are going. Are we on the right track? Are we meeting those targets?

Ms Thompson:

We are monitoring the financial position very closely with the board and the trusts. You are right to say that that is where the bulk of the expenditure lies. The way that we see it, and what I have described to you, is that, yes, we are pretty much getting there with the overall financial position. We are not there yet, but we hope to get there and live within the budget available by the end of the year. The difficulties lie in performance and service issues and with whether patients are getting all access to treatment, as they might expect.

Mr Wells:

You have been fortunate to discover halfway through the year that you are presumably going to hit your target. If you had found out anything different, you would have had real trouble turning the thing around, given that it is so late in the year.

Ms Thompson:

A considerable amount of work has been done on this, as you would expect. We have tried to identify solutions and ways in which to manage the situation. The Minister, the Department and the board have been involved in finding the best ways in which to manage it. We will continue to keep a very close watch on that during the year. Things can always swing, particularly in a demand-led service. In a £4 billion budget, things can swing. The budget is never, ever static, so

we keep it under continuous review.

Mr Wells:

I have met three of the five trusts in the past month and have asked them this question. They say that they think they can make it this year but that it will be impossible next year — absolutely impossible. That is coming from very efficiently managed boards of trusts that have, so far, played by the rules and done their best. They think that they can make it this year but are saying that it cannot be done next year.

Ms Thompson:

Our sense, in tandem with what you have heard directly from the trusts, is that they will make it, to use that phrase, during 2011-12. That is what they intend to do as we look at the position now, subject, obviously, to things changing through the year. The years 2012-13 to 2014-15 will be very challenging. We are looking at that and trying to assess what the scale of the challenge will be and what can be done around that. The health and social care review will be very informative. The message that you are getting — that this is an exceptionally challenging year — is one that has also been fed back to us from the trusts.

Mr Wells:

I have one final question. Where is capital in all this? This seems to be all about revenue.

Ms Thompson:

You had asked for an update on the current expenditure budgets. This is all to do with current expenditure. Capital expenditure is not my area, but my understanding is that it is forecast to be spent in line with its budget for 2011-12.

Mr Wells:

John Cole has not been asked to give up money to help balance the revenue situation?

Ms Thompson:

No.

Mr Wells:

What was planned is being stuck to.

Ms Thompson:

That was discussed at the Committee the last time. The rules around whether you can move capital money to revenue money were, effectively, signed off on as the budgets were set.

The Chairperson:

Although those rules have been tweaked in the past.

On the back of that, next year is going to be very difficult. Can you give us any hope at this stage that the same calculation on pay can be pulled out of the bag to make things a wee bit easier? Is the calculation now being done on the basis of overestimating what we will need?

Ms Thompson:

During our work on this, what we will do with all the things that have moved is to say that some of those will be of benefit in future years. The pay calculation is a benefit to future years. Therefore, we will be updating the financial position as we see it for 2012-13, reflecting that. Some of the things that have been talked about would not be sustainable into the second year, but the pay calculation and, for example, the pharmacy calculation would all be expected to be sustained into 2012-13. Therefore, as we look at the financial position for 2012-13, we will immediately update it to include those particular items. To go further than that, we would expect the reasons behind the savings in 2011-12 to be rescrutinised for 2012-13 to ensure that we understand the full picture. That is part of what we normally do with budgetary processes.

The Chairperson:

Do you expect that to include the £11 million for consultants' bonuses that we have heard about in the past?

Ms Thompson:

We will be looking at all areas of the budget to see where we are currently at and, as we roll it forward, what has happened. If we were to find that something had happened in 2011-12 that is sustainable and can go forward, we would bring that in, and that is part of our budget processes as we work forward.

The Chairperson:

Sorry, Gordon, but I got a bit carried away. You are next.

Mr Dunne:

You are all right; I understand. It is your enthusiasm.

The Chairperson:

Were you going to say that you are used to it?

Mr Dunne:

You are right. We are getting used to it.

In June, the Committee was told that £72 million was still to be found. Is that correct?

Ms Thompson:

That is correct.

Mr Dunne:

You have got that down to roughly £15 million, which is some going. The staff issue has been fairly well covered. Remind us whether a pay freeze has been implemented.

Ms Thompson:

The pay freeze is the same as that across the public sector. There is a pay rise only for people who earn under £21,000.

Mr Dunne:

The freeze is still in place, then. Are there any plans to cut staff?

Ms Thompson:

The trusts will be working through what their budget means for them, and they will be ensuring that they have the right staff in the right place for the right services.

Mr Dunne:

Your briefing paper states that a review was conducted to investigate the extent of actual pay

growth. Is that part of that?

Ms Thompson:

No, that is definitely not about staff cuts. The actions that I have talked about today are not about staff cuts.

Mr Dunne:

Staff cuts are not in the briefing paper?

Ms Thompson:

No.

Mr Dunne:

Your paper mentions "managing pressures in dental expenditure." What does that mean?

Ms Thompson:

We currently have an overspend to the tune of £5 million in the dental budget. Effectively, it is a demand-led service, in that if a patient turns up and a dentist is there to treat that patient, the dentist can expect remuneration for that treatment from the Department. We currently have an overspend in that budget, and the paper looks at ways in which we can potentially manage that overspend in future.

Mr Dunne:

We are aware of people who have difficulty in getting dental treatment. Is that issue being looked at?

Ms Thompson:

Access is a fundamental part of it, but, from a financial perspective, the actual spend in that area is forecast to be overspent by £5 million, which is a significant amount in an £89 million budget.

Mr Dunne:

Therefore, we are looking for efficiencies?

Ms Thompson:

Yes, in the same way in which we are looking for efficiencies throughout the entire budget.

Mr Dunne:

Are significant efficiencies in dental expenditure needed?

Ms Thompson:

We are looking at efficiencies across the board and ways in which those can be managed.

Mr Dunne:

Is there a risk that we are putting off until future years the evil day when there will be excessive pain with cuts? What is being done?

Ms Thompson:

As we have already talked about, the 2012-13, 2013-14 and 2014-15 financial years are still exceptionally challenging. The health and social care review has been commissioned to look at the ongoing model of service provision and what that might look like. On the financial side, we are looking at ensuring that we have as sound an understanding as early as possible, particularly about 2012-13, which is only six months away. We are working through that, and our current view is that the position for 2012-13 will be very difficult. When we combine that with the fact that some patients are not currently able to access services that they may want to access, the situation is ever more challenging as we look into the future.

Mr McCallister:

Do you mean that, by the time the real pain comes, my constituency colleague Jim Wells could be Minister? I must hoke out some of what Jim said last year when he was Chairperson of the Committee. Julie, we will not get you involved in the grubby world of party politics.

You have done remarkably well to narrow the gap from £72 million to £15 million, and when the gap gets to £15 million, it starts to seem pretty manageable. Jim asked about how tightly you are monitoring the situation. We are so far into the year that, if something were to go wrong or if someone were to discover suddenly an overspend, you would have no time to turn it around. The review may result in more money being available somewhere.

When any Minister or Department changes a service, inevitably there is a cost. We heard a lot of talk about the safety of the service. Is it safe?

Ms Thompson:
Those questions raise a range of issues.

We monitor what is happening very closely on an ongoing basis. We need to do that for the reasons that you point out. On a budget of £4 billion, things move: that is just what you expect to happen. The issue is to keep an eye on things, to make sure that the board is working in close contact with the trusts and that we understand how that is all following through and ensuring that everybody is aware that we do not want an overspend or underspend situation at the end of the year.

The issue is getting early information passed through and trying to get a handle on the best forecasts. We continually impress on organisations that that needs to happen and that we must have early sight of any issues. Equally, with the size of our budget, it is to be expected that some things will go to the good and others will go in the other direction, and we need to manage that.

It can take time and cost money on a non-recurrent basis to make changes. Changes can require investment in, for example, community areas or GPs if you want to shift from the acute sector into other areas, as was discussed earlier. So it can cost money, which we need to factor in, because it cannot be assumed that you simply take the saving if there is a cost that accompanies it. Again, we have to factor all that in.

Ultimately, services have to be safe. However, does that mean that patients have to wait a bit longer to receive treatment? Safety is obviously a daily judgement call in the trusts. They have to ensure that services are safe.

Mr McCallister:
I take that point. Generally, whatever way services are changed, there are rarely immediate savings: payback is usually later down the line because the costs are more upfront. If you are in a difficult financial year this year and have a very difficult next few financial years, you will struggle.

The Finance Minister promised to top-slice if a case were made. The difficulty is that we have already top-sliced to pay for tuition fees. When do we stop top-slicing? When do you close another Department to fund health? That is a difficulty with making some of these decisions. At some point, the Finance Minister will not be able to continue top-slicing other Departments if he wants to keep schools open. The Executive must decide that.

The Chairperson:

I have a wee supplementary to John's line of questioning. It is only six months since the Executive were told that the health service was on the brink of bankruptcy. At that stage, the figure for the shortfall was £800 million. That was brought down to £177 million, then to £72 million in June, and now it is £15 million. Was the previous Minister sold a pup? Was the crisis manufactured? Were we in such a big crisis if we are now in a position where the shortfall this year is £15 million?

Ms Thompson:

The £800 million referred to the financial shortfall by 2014-15. The number that was quoted for the 2011-12 financial year was £300 million.

As Dr McCormick pointed out at the meeting on 29 June, that was re-scrutinised. When developments that should have happened were taken out, and we got down to the real essentials, the figure became £177 million. We then looked at that £177 million and kept looking at it until now. However, at all stages, it was always based on the information available at that stage. Equally, there have been reductions and considerations of budgets to see what can be done. We have talked about it, whether it was the Fire and Rescue Service, the trusts or whatever, and looked at those budgets which, in an ideal world, you would not want to cut. However, in order to live within the budget, those have had to be cut. We started with the figure of £177 million, and all the things that have come off that have been the result of proactively trying to live within the financial position as it is now.

Mr McCallister:

As Julie said earlier to Jim, that means that people will wait longer or not get treatment in Belfast. Jim's example was that people would get treatment in Bedford that they would not get in Belfast.

Ms Thompson:

A significant part of that is being managed by the residual demand issue not being funded and, therefore, people living within the resources that they have and the implications for patients.

Mr Durkan:

I have a question about the £177 million and its reduction to £15 million. Although I care about John's congratulations on your work from getting it from the worst figure to the new figure, you cannot help but think that it might have been a worst-case scenario that we had been given to make this a less bitter pill to swallow — a generic one, perhaps; it is cheaper. *[Laughter.]*

Mr Wells:

That is a good line. I wish I had thought of that one.

Mr Durkan:

How responsible was it to have had those figures out there in the first place? It is the sort of thing that a local council does when it leaks information that there is going to be a 15% rise in rates, and it then comes out with a rise of 5%. There are serious concerns about the effect that it is having on access to services, and it is does not bode well for the next few years if people are feeling the pain already. It can only get worse.

What scope is there for contingency or emergency scenarios, such as a pandemic, an epidemic or a care-home operator doing a midnight flit, whereby the Department would have to ride to the rescue? Does it have a horse to come in on? I am concerned because I do not see that written down in the budget.

Ms Thompson:

We do not hold money back explicitly for contingency. You will be aware that, for the swine flu pandemic, we had to bid for additional resources through the monitoring rounds to deal with that situation. However, we closely monitor what is going on on a month in, month out basis. We are looking for issues, either positive or negative, about what is going on. From the historical running of the budget and its scale, potentially, if money is held back on contingency, we will end up with an underspend if those things do not happen. In a financial climate such as this one, holding money back that ultimately is not spent is not viewed by the Department as the best basis for a budget. That is why our historical underspends are very low compared with the size of our

budget — £3 million to £4 million — because we do not deliberately hold money back. Obviously, if there is a shock to the system and something happens really late in the financial year, it could be said that we are leaving ourselves at risk to that. However, on the basis of our financial work, to hold money back at this stage would not be viewed by us as the best use of our resources.

The Chairperson:
What about other Departments?

Mr Durkan:
I suppose that we are in a permanent state of emergency.

Mr Wells:
I can see the pain in Mr Gibson's and Mr Toogood's faces. You are obviously greatly annoyed that you have not had a chance to come in. You have all those wonderful briefing notes, and you have not had a chance to get a word in edgeways.

Mr Paul Gibson (Department of Health, Social Services and Public Safety):
I do not feel bad about it.

Mr Wells:
The headline here is that the Minister has balanced the books. To get down to £15 million in a £4·3 billion budget is an extraordinary performance, and it augurs well for this year. That is extremely good news. Is it possible to achieve the same miracle, as it were, next year, using the same devices, or do we require something much more fundamental to get the books to balance? Has swine flu been built into the estimates for this year?

Ms Thompson:
For next year, we need to run through what the figures tell us. We intend to do that shortly to find out where we can see benefit in running forward the 2011-12 initiatives. As every year passes, it gets harder and harder to balance the books. That is where the issue about change, the need to do things differently and the consideration of alternative models comes in.

Then there are timing issues: what can we do in time for 2012-13? We are working around

that, and we hope that John Compton's review informs that. The challenges are still there for 2012-13. We will do the work and use all the learning from this and all the experience in the Department and across the bodies, and work with the Minister on the options and proposals that he wants to put in place in order to look at the financial position for 2012-13. At present, it looks very challenging, and we need to continue to look at the full details to see what is doable. It does not balance in any shape, matter or form at this stage, but we need to work through that. If an initiative has been in play in 2011-12 that can still be in play in 2012-13, we should make sure that those things are still happening.

Mr Wells:
Are you basing your assumptions on counting up the savings? Do you think that there will be something radically different in 2012-13 in how we provide those services?

Ms Thompson:
As we look forward to the 2012-13 position, we get to a point whereby, if we continue to stay as we are — that is where the £800 million analysis effectively comes in — that is the scale of the pressure that we are trying to manage. That is equivalent to the £20 billion pressure in the NHS in England. The scale of the financial pressures in health is the same across the board and reflects demographics, residual demand, and so on.

As we look at 2012-13, we ask what we can do about it, what is viable, what will deliver savings in that year, and we cannot simply count on what was done in 2011-12. Blatantly, more has to be done. Our consideration of that will no doubt be informed by the review and by the Minister's views on where we should go in 2012-13.

Mr Wells:
I asked about swine flu.

Ms Thompson:
An element has been held back for swine flu, but it is not a significant budget. Normal flu vaccine costs, and so on, are in play in the budget, but I suggest that, if a swine flu pandemic of the order of a couple of years ago appeared, we do not have the capacity for it. I referred to that earlier. That is no different to where we were two years ago.

The Chairperson:

Jim, before you run out and do the BBC interview, I want to point out that this is cold comfort for people who are waiting on anti-TNF or cancer drugs. You said dentistry is demand-led; if people cannot get access to an NHS dentist, being demand-led is not much good to them.

Fertility issues came up in questions for oral answer on Monday. The Minister recognised the fact that one cycle is not worth tuppence and that it does not cost an awful lot more to do three cycles of fertility treatment, but it increases chances considerably. Value-for-money decisions such as that could be made. The public would get a better bang for their buck if the right decisions were made in finance. I would not get too —

Mr Durkan:

That is an interesting choice of terminology. *[Laughter.]*

The Chairperson:

It was not meant to lower the tone, Mark.

Mr McCallister:

You got it in Hansard and everything. *[Laughter.]*

The Chairperson:

We cannot be too self-congratulatory yet, given the people who are still waiting for NHS services to kick in for them. We recognise the fact that the budget will be challenging over the next number of years. I reiterate the point that, to scrutinise those budgets and have an input, we need that information as early as possible.

Julie, thank you very much. Peter and Paul, you have been great. *[Laughter.]*

Mr Gibson:

A faultless performance — faultless.

The Chairperson:

It does not surprise me that they stick the woman out front and let you take all the abuse, Julie.

There is a wee bit of gender solidarity going out to you, but only a small bit. *[Laughter.]*

Thank you for that. We will have you up again very soon when we see the Minister's priorities, which we want to see as quickly as possible. If at all possible, we will see you at the same time as the Minister. We would like a copy of the Department's return to the Department of Finance and Personnel for October monitoring. We would like to see what has been bid for.