Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

October 2014 Monitoring Round: DHSSPS and DFP Officials

1 October 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

October 2014 Monitoring Round: DHSSPS Officials

1 October 2014

Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Ms Paula Bradley (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Gordon Dunne
Mr Kieran McCarthy
Mr Fearghal McKinney

Witnesses:

Mr Bill Pauley	Department of Health, Social Services and Public Safety
Ms Catherine Daly	Department of Health, Social Services and Public Safety
Ms Julie Thompson	Department of Health, Social Services and Public Safety

The Chairperson: I welcome the officials who are here today to discuss the October monitoring round. Julie Thompson, Catherine Daly and Bill Pauley, you are very welcome to the Committee. I will hand over to you, and then I will open it up to comments or questions from members.

Ms Julie Thompson (Department of Health, Social Services and Public Safety): Thank you, Chair, for the opportunity to provide evidence to the Committee today on the Department's proposed approach to both current expenditure and capital investment expenditure for the October monitoring round. Since our attendance at the Committee last week, we have had the opportunity to discuss the proposed approach with Minister Wells, including the nature, scale and scope of the bids to be submitted and their prioritisation.

We have considered a range of factors for current expenditure, the most significant of which is the financial context for 2014-15. As outlined in the briefing paper, and as we discussed last week, members will be aware that, after June monitoring, the Department faced a deficit of £140 million to manage in 2014-15. Given the uncertainty in the financial position, we have already taken steps to constrain some expenditure where it is possible to do so, and hence manage an element of the unfunded pressures internally. Unfortunately, that is having a detrimental impact on performance, most notably in waiting times. We are also aware of pressures outwith the Department in, for example, some community and voluntary bodies and the use of the independent sector in providing services to Health and Social Care (HSC).

Notwithstanding the impact on performance, from a financial perspective those constraints on expenditure and delays in making commitments have meant that the unfunded pressures have been

reduced by some £10 million. That means that bids of £130 million are being submitted in the October monitoring round. In overall terms, the bids are based on the areas of unfunded and uncommitted expenditure that were highlighted in the previous Minister's letter of 28 August and are, therefore, directed towards delivering a range of critical front line health and social care services. For example, there are substantial bids in relation to unscheduled care and patient flow issues, which would mean that trusts would not need to reduce agency and locum doctors or agency and bank staff, or domiciliary care packages, as is currently proposed in their contingency plans, and that they could make the necessary planned investments in ED capacity and measures to improve patient flow.

Bids are also being made in a number of other areas such as elective care and specialist services such as drugs, cath labs and cancer, as well as a range of public health initiatives, mental health and learning disability resettlements, and pay awards. We are bidding for Transforming Your Care (TYC) transitional funding to enable progress in the implementation of transformation, and we have prioritised the bids in line with DFP requirements.

Turning to capital expenditure, as we outlined last week, the key constraint is that any bids must be for projects that can be fully spent in 2014-15. Our approach to capital is that two bids will be submitted. The first is for an additional £12 million to provide additional resources to buy medical and other equipment, address minor works, improve the clinical environment, improve vehicle transport and address ICT needs. The second is to retain and use the €3 million from the Republic of Ireland as part of its contribution to the Altnagelvin radiotherapy project.

In conclusion, all our proposed bids will help to mitigate the detrimental impact on front line health and social care services. However, given the serious challenges facing the Department and the late stage in the financial year, decisions are very urgently needed on the additional resources to be made available if the worst of the consequences are to be avoided. We therefore strongly recommend that the Department's bids are considered favourably by the Committee. We are, of course, happy to take questions from members.

The Chairperson: Thank you for that, Julie. May I just say that that is a very different bid? I think that that is the position: it is a very different bid.

Ms Thompson: The format has changed, but the actual figure work behind it is substantially the same.

The Chairperson: The paper that we have today states that, as you have outlined, the Department intends to bid for £130 million in the October monitoring round, compared with the June monitoring round bid of £160 million. What are the key differences?

Ms Thompson: At the start of the year, we were looking at a range of pressures that were likely to appear across the year. In making the October monitoring round bids, as the Committee is aware, we looked to see where expenditure could effectively be stopped, curtailed, brought back or limited in some way through delaying service developments or implementing contingency plans. We have therefore framed the bids around those options, which were set out by the previous Minister at the end of August. The figure work is substantially the same.

We have taken some measures to manage those pressures ourselves. Equally, there has also been a realistic assessment of what could be spent between now and the financial year end. The actual work around it is exactly the same, and the difference in style is more about the fact that this is now looking at what is expected to be spent between now and the end of the year. That is the money that we need in order to sustain those services. If we do not receive the money, then the service developments have to be stopped or the contingency plan measures have to be put in place. When we did it at the start of the year, we were looking at the pressures as they were presenting across the entire year.

You will see that there is a lot of similarity in where the bids fall, including unscheduled care, which was there before, and elective care. We are focusing on similar areas, but the bids at the moment are positioned around how and where expenditure could effectively be stopped between now and the end of the year. That is what we need the money to bridge.

The Chairperson: There are also quite a lot of differences, particularly in relation to policy focus. I think that we can get into that and where the priorities are. Have you taken decisions about what not to bid for?

Ms Thompson: The bids are focused, as I said, on the uncommitted expenditure. That is the emphasis of the October monitoring bids. It is not about strategic prioritisation; it is literally about where money could be stopped. It comes from all the work that was done around uncommitted funds and where you could provide additional money. If that money is not provided, then the service development cannot happen, and that will obviously have consequences in what will happen on the ground for patients and clients. The figure work within the bids is all about the actual level of spend that could be stopped between now and the end of the year and about bidding for that money to allow those services to continue.

The Chairperson: I just find it strange that a bidding process would not be about strategic prioritisation.

Ms Thompson: It is the reality of where we are in the financial year, with £140 million of pressures presenting. We have had to look at the options; at what can be done about that. The reality is, as the previous Minister described to the Committee at the beginning of September, that we would not want any of this to happen. This is all about ensuring that we have the resources that we need to put those services on the ground. If we do not get the money, the services cannot go on the ground, and that will have severe and challenging consequences for the patients and clients in Northern Ireland.

The Chairperson: I want to move on to something about strategic prioritisation, because I think that that is critically important. Obviously, and I have made this point to you a number of times, there should be a strategic priority list of what the priorities are going forward. That leads me on to the whole issue about Transforming Your Care. That was the great hope for the delivery of our new health service and the shift left from acute care to community and primary care — all of that. In June, we had a bid for £21 million of transitional funding. It was category C, which the Committee rightly challenged, in my view, at that stage. In October, the bid is for £2·6 million, and it has been moved to category B. What is the rationale for that?

Ms Thompson: Catherine can pick up the specifics on TYC, but the issue is that what we have had to look at now is where spend has not been incurred. The additionality that could go into TYC between now and the end of the year is £2·6 million. That applies to every other category of bid in the list. The things that are at the top of the list now are, as we explained last week, around protecting patient flow, ensuring that the hospitals can manage through the winter, ensuring that front line services are protected and ensuring that the contingency plans that the trusts came up with would not actually be implemented because of the damage that those proposals would do. Those are the things that are coming to the top of the list this time.

TYC, as you say, is in the second order category because it is something that we most definitely want to do. The difference in the numbers is because of the change in the way the bids have been put together. The amount of money through the year, effectively, was £21·3 million. To this point, money has already continued to be spent on TYC, and therefore this bid reflects the remainder of the spend between now and the end of the financial year.

The Chairperson: With respect, Julie, you have just outlined to me the strategic priorities for TYC, but five minutes ago you told me that this is not based on strategic priorities but on technical issues. Which is it?

Ms Thompson: Within the actual bids that are there, they have been given a strategic prioritisation A, B and C. What I am saying is that when it comes to doing these things or not, they have come from a list of uncommitted funds. These are not the things that would come to the top of the list if you had free rein to say, "These are the things that I would like to stop". The things that you can stop are simply a matter of fact. If people are already effectively employed, you cannot stop that expenditure; that expenditure will continue. These bids are, therefore, around the elements that you can stop and on which you have discretion. In that sense, they are not strategic; they simply happen to be a look at what is uncommitted at this stage and, therefore, they are options that are available. Now that we have looked at that, we have tried to give them a ranking that respects the primacy of patient flow and safety and quality of services for patients.

The Chairperson: Again, people looking at this would say that TYC is the main plank for providing some of the outcomes that a lot of these pieces of work are attempting to do. We have £21 million bid for in June with TYC listed as category C; we have it upgraded now to category B and only £2·6 million.

Ms Thompson: That reflects the level of spend that is able to be spent between now and the end of the financial year. This bid is all about what can be spent between now and the end of the financial year and where we need additional resources to enable that to happen. That is the difference to the £21 million, which was viewed as the expenditure through the year.

Ms Catherine Daly (Department of Health, Social Services and Public Safety): May I pick up on that, Chairperson? I will just go back to the June monitoring figures of £21·3 million. The approach we have had to take has probably been confusing because of the funding that was not secured. A bid of £21·3 million was made for TYC, and when we looked at what was not committed, we had a figure. However, within that £21 million, £12 million in expenditure was already committed and was being implemented. That is currently taking place.

As Julie said, in moving forward on what we are bidding for now, we had to look, given the extent of the pressures that we are dealing with, where there was funding, not at what you would want to stop but simply what you were able to stop. An element of TYC came into that. As time has moved on there are some elements of the bid that, as we get into October, halfway through the financial year, it would not be possible to do. The elements that are identified here under the £2·6 million figure are quite critical. The case has been made very clear in terms of the benefits, but even with these, even now, timing is critical. Even for the atrial fibrillation expenditure of £1·5 million, the integrated care partnerships (ICPs), the board and the GPs are telling us that it is critical to have that money now in order to run with flu clinics. These are the sorts of things that mean that, if timing runs against us and we miss the flu clinics, it is not possible to spend that money in the way it was intended. That is what is happening as time progresses.

Mr Beggs: I understand that the local commissioning groups had come up with some strong business cases for adopting new models and collaborative working so that all professionals could come together to agree new methods, yet it does not seem to be funded. Are we in danger of demotivating those people and preventing the new methods of working that bring about those savings so that we do not have to amputate limbs and the earlier interventions will result in fewer people having to face that? Has all of that been taken out, and are you at risk of these local commissioning groups falling apart because we are not funding them?

Ms Daly: This is absolutely at the forefront of our thinking in the whole transformation programme. It is important to keep up that momentum. Within the bid here, £1 million is being sought to enable equity of clinical priority pathways, and that is some of the work that I think you are talking about. That has already been implemented in the Southern and Western Trusts, and the purpose of this bid is to enable that to be taken forward in the other three trusts so that, not least, you have equity of access and provision across Northern Ireland. We have established a number of pilots and education programmes, and those include expenditure on a falls prevention pilot; patient education on a diabetes, stroke and early supported discharge programme; and education for GPs in the treatment of chronic obstructive pulmonary disease. So, there is a whole raft of things. If we were able to secure the funding on those now, they could actually be delivered. That would help to build momentum. On the bid that came through in June and what has not been secured on that, that still needs to be delivered in the transformation. We need to look at that more moving forward.

Mr Beggs: It strikes me that some very common-sense areas that would be better for patients and better for the health service are not being implemented.

The Chairperson: Thank you, Roy. On a similar vein, there is the issue about the bid for public health. It was £10·5 million in June, and it was priority A. Again, in a similar vein, where we look at a shift from acute to community, primary and interventionist work and all of that, in October, this bid that is in front of us today is for £3·5 million. Why the shift?

Ms Thompson: Again, it reflects the spend that has continued to be incurred since the original bid in June was made. The bid that is outstanding that has not been invested at the moment is £3·5 million, and that is the element that we are bidding for. Expenditure has continued to happen through the period between June and October, and that is why the numbers effectively have been changed. It is to reflect what has already been incurred. We are not bidding for what has already been incurred; we are bidding for the amount of money that is expected to be incurred between now and the end of the year where we had wished to put public health services on the ground.

The Chairperson: Is that out of the £20 million that you were allocated?

Ms Thompson: As we discussed, we have not actually got the £20 million yet.

The Chairperson: Julie, in answer to both of those questions, you have said that money has been incurred in these areas and that this is what is left, almost, that you have to bid for. How do we know what is left, if you are not telling us what you intend to spend the £20 million on? It seems to me that the policy focus of this has shifted. Public health has now shifted from priority A to priority B.

Ms Thompson: Those are two slightly different issues, and I will deal with prioritisation in a second. On the difference in the bids, a large portion of the original bid of £10 million in June was to do the vaccination programmes. Those vaccination programmes have happened and are happening, and had to be committed to as we work forward. That spend is happening as we speak. The bid that has not happened is the £3·5 million, and we are focusing these particular bids on where we have not got the money, effectively, to continue the investment that was already there. We will come back to where the £20 million effectively gets spent. What we have done and how we know is because we have done an entire review of all of what is not committed to date and, therefore, where we still need additional resources to allow those things to happen.

The prioritisation that is in play is effectively to say that patient safety comes absolutely as first priority. Patient flow comes as first priority, and, as much as we would love public health and TYC and everything else to all be at the top of the pile, they cannot all be at the top of the pile. So we are trying to give some sense of prioritisation to that. Depending on the money, if we get the additional resources, then we would look across the entire patch. As I said, it is not as simple as drawing the line where the funding ends; you would look at funding an element of each of the bids. That will ultimately be a decision for the Minister.

The Chairperson: I am really unclear about this. You are saying that, although there was a public health bid for £10 million, you effectively were able to spend £7 million without getting that bid.

Ms Thompson: That is why we are short £140 million as we look at it now.

The Chairperson: But you were short in June.

Ms Thompson: Yes, and we are still short £140 million short. The gap that we have got is £140 million, and we have identified the areas that we could effectively look at to control, manage or reduce expenditure and that is what we are bidding for. In reality, those are the only things that we can do in order to break even. You are absolutely right; the vaccination programmes have proceeded, and that is one example of why we are £140 million short. Those vaccination programmes are ongoing and are working through as we speak. They are not the focus of a bid because the spend is not being incurred on those; the commitments have already been made. The bid is about where we have not made commitments and where we can reduce and control expenditure.

The Chairperson: OK, but in that context, where does that leave the public health agenda and the priority that was given to spending money to prevent ill health and to target health inequalities?

Ms Thompson: It leaves it needing another £3·5 million to deliver what it wanted to deliver within 2014-15. If we get additional finance, whatever the scale of it may be, the Minister will need to decide where that additional funding goes. Whatever we are not able to finance will have to be delayed or stopped. That applies to every single bid right the way down the list, because it is looking at where the options are available in order to control a managed spend between now and the end of the year. If the money does not come, then everything on this list effectively stops in terms of service developments or needs to be implemented in terms of contingency plans and pay restraint.

The Chairperson: A number of members want to come in on this, but one of the other issues is a bid for £15 million for pay awards. That did not appear in June. Has a need for this money suddenly emerged?

Ms Thompson: Again, Catherine will talk about the details of the pay restraint. It is exactly the same issue, whereby we had a pressure of £160 million; we looked across the piece at where bids would be put in place in June; and we came out of that June monitoring round with a promise of £20 million that we have not yet received. Given the stage of the year, we had to look at what the options are in order to break even, and one of those options is to not implement the pay award that we would otherwise have. Catherine can take you through the detail of that. If we get the funding, that pay award can go

forward. If we do not get the funding or if we do not get enough funding, the Minister will need to establish what his priorities are.

The Chairperson: Why did it not appear in June?

Ms Thompson: Because in June we were looking at the list of pressures across the entire system, and those were identified at that point. This is a list about uncommitted funds and where we need to take decisions or where decisions need to be taken post-October monitoring to identify what would change or what would have to be stopped.

Ms Daly: Can I pick up on that, Chair? This is an example to explain that difference between June and October. In June, the bids were put forward to address all the pressures across the Department. When we did not did get the funding, we had to look across the budget to see what could actually be stopped. Within the overall budget figures, provision had been made for potential for a pay award. An element of that would not have been committed. There are elements of pay that are contractual obligations and elements that are at the discretion of the Minister. In looking at what was in the baseline, we looked at what would be required to deliver on contractual obligations and maintain relevant pay policies. That highlights £14·9 million against all that which is not currently committed under contract or under any agreement, which could be used to offset other pressures. That is why the Minister has been clear in saying that these are not the things that he would want to do; they are simply the things that can be done.

The Chairperson: But if we are talking about the document in front of us showing uncommitted pressures, and bids are supposed to be about major or unforeseen circumstances, do you agree that those are major and unforeseen circumstances?

Ms Daly: Absolutely.

The Chairperson: What is in front of us today is major and unforeseen?

Ms Thompson: It is the entire £140 million that is major and unforeseen, and that is driving the bids in front of you. The previous Minister was very clear to the Executive and the Health Committee that these are the options. Either funding is provided to allow those things to happen, or they will have to be stopped. It is the drive of the £140 million that is major and unforeseen. He has looked, and we have looked, right across the budget to identify what the options are. That is what will be put to the Executive table. Either money is provided to back those proposals to go ahead, or they will all stop.

The Chairperson: Well, it is £130 million now. I know that Fearghal wants in on this, but I just want to make a wee quick comment on it first, because it is related. On the issue about the pay rise, there is also reference to bidding for money for eight new clinical excellence awards. That has been subject to much debate around the £34 million to senior consultants for bonuses. That process was to be frozen.

Ms Daly: The clinical excellence awards were frozen for two years during the pay freeze, because clinical excellence awards are deemed to be part of pay. It has also been recognised that they are an important element of recruitment and attracting the appropriate calibre of people. What has been going forward is a reduced number of clinical excellence awards, and money has been freed up from within the budget as a result of that. Again, under current circumstances they cannot be met. It is the higher clinical excellence awards only, and it is a much reduced number.

The Chairperson: That does not make it sound any better, I have to say. It says that it is bidding for money for eight new clinical excellence awards. Again, I suggest to you that, at a time when there are major pressures on our front line services — I do not need to repeat all that is going on in our emergency departments — we have, at the senior, top tier of the system, a bid for additional money. It does not assist the agenda to eradicate some of those difficulties and deal with health inequalities properly. Fearghal, you wanted in on that.

Mr McKinney: I will leave it for the moment, Chair, until I ask my own questions.

The Chairperson: There are a number of people that I want to bring in; Kieran first.

Mr McCarthy: Thanks for being here. I am disappointed that the Minister is not here. Going back to that £20 million, Julie, last week when you were here you said that you did not have that, and you have still not got it. If it is going to take you that long to get a mere £20 million out of £160 million, it is going to be a hell of a long time before you get the £160 million, and you do not even know what to spend it on when you get it. What is going on? Twenty million and you are desperate for £160 million and you have not got it, and so the problem goes on.

Ms Thompson: The £20 million, as I understand it, will be confirmed through the October monitoring process. That is the process that we are working through at the moment. In terms of decisions on that, all of the material from Departments is to be submitted tomorrow and then it will pass through DFP and into the Executive from there. You are absolutely right; we need very urgent decisions about how much additional resource the Department will get and, moving from there, about where that money will be allocated. Without it, spend continues and we do not know exactly what we can deliver through the remainder of the year.

Mr McCarthy: I hear what you say, but you have been given £20 million in the June monitoring round. That was at the end of August.

Ms Thompson: It is conditional. We have not received it yet. It will only be —

Mr McCarthy: Conditional on what?

Ms Thompson: Conditional on ensuring that steps are taken in order to break even. We are discussing that very issue and whether we can break even as we speak. It is part of the decision-making process around October monitoring.

Mr McCarthy: In a response to the Chair, you mentioned that a lot of that funding is dependent on the hospitals managing through the winter. You cannot even manage through the summer. We are still in the summer. As the Chair said, the Royal had difficulties in A&E, and I think that the Ulster Hospital had to close, or it certainly had to direct patients away from the hospital. This is still the summer, and you are talking about managing for the winter. It is not going to happen. Patients will suffer, and something worse may happen.

Ms Daly: I will pick up on that. As you see in our briefing paper, there are bids for unscheduled care. I absolutely note your points about the level of activity and performance during the summer months. There have been issues with 12-hour breaches in the Belfast Trust. That is something that —

Mr McCarthy: And at the Ulster Hospital this week. They closed completely — no admissions. They were directing patients to wherever they could go. Surely that is disgraceful.

Ms Daly: That is certainly a very high priority for the Department. I mentioned to the Committee last week that a task group had been established, which is chaired by the Chief Medical Officer and the Chief Nursing Officer. It is specifically looking at those issues. The objective is to ensure the elimination of all avoidable 12-hour breaches by early November and to have significant improvement and progress on delivery against the four-hour target, because that is not where it should be. I absolutely take your point about where things are, but this funding is critical in order to take forward and address the pressures that we know the trusts will face in the winter months and to fund some of the areas that will lead to that throughput in patient flow and ensure that there is an effective flow of patients through the hospital and effective discharge. There are a number of elements in that bid, and they are all linked. I absolutely understand what you are saying about where things are, which is why the funding that is needed to progress it is absolutely critical.

Mr McCarthy: The future is really bleak if any of those bids for funding are not met quickly.

Ms Daly: I could not say that it would not be. This is critical, and it is a critical area.

Mr McCarthy: It is disgraceful.

Your briefing paper states, as I understand it, that the Department has managed to find £10 million in savings since you were here last week. How has that £10 million been saved? What have you chosen not to fund and why?

Ms Thompson: The £10 million comes from looking right across the budget to see where funding could be stopped. We discussed TYC, for example, where the numbers have changed. We have looked in the Department and in the HSC and have tried to manage some of those pressures without making a bid to the centre. The £10 million is a combination of that. It is exceptionally complex because it goes right across the budgets, but it is better to put in a bid for £130 million than £140 million.

Mr McCarthy: I am getting more confused as we go on. I will leave it to others.

The Chairperson: That point is important. Will you give us examples?

Ms Thompson: We looked at clinical excellence awards — Catherine mentioned them — ICT budgets, blood transfusion —

The Chairperson: Where did you find the £10 million? I am not asking where you looked for it but where you found it.

Ms Thompson: Those are the examples that I am talking about. TYC has been reduced. We looked right across the budget to identify — sorry, maybe I am using the wrong word to describe what I mean — how savings could be pulled out of those areas and said, "We would have wanted to put money into those areas but, because of the financial position, we have tried to manage some of that internally in the Department". That is what brings the unfunded pressures down from £140 million to £130 million. It is exceptionally complex and is right across the entire budget.

The Chairperson: As I am listening, I am getting more confused. You talked earlier about the TYC bid being for what was left to be spent, but you have just said that you have reduced the bid. Which is it?

Ms Daly: It is a combination of both. In June, the bid figure was £21·3 million. Of that, £12 million is already committed and is being spent on the ground, and there is now a bid for £2·6 million. That means that, in overall terms, the pressures from TYC have been reduced by £6 million, because it simply is not possible to take forward those elements of expenditure. That is one element, but, as Julie said, there is a whole range of things. I will use TYC as an example: it is a combination of the original bid, the element of expenditure that is already committed and the further bid, but there is an element that cannot be taken forward, and that is £6 million, so that contributes to reducing the unfunded pressures.

Mrs Cameron: Thank you for your presentation today. I have to say that I do not envy you any of your roles.

In June, the Department bid for £20 million for specialist services, and the October bid is £10 million. What has been taken out of that bid since June?

Ms Thompson: The June bid reflected the pressure through the whole year. The October bid is based on the amounts of money that we can spend between now and the end of the financial year. The areas are the same, but the bid reflects what is needed at the tail end, between now and the end of the year. That is why the bid is lower than it was in June. The uncommitted element of the bid remains in the October monitoring bids.

Mrs Cameron: In June, the bid for elective care was £30 million, and it was category C. In October, the bid is £27 million, but it has been moved up to category B. What is the rationale for changing the priority?

Ms Daly: The issues are the same: expenditure continues to be incurred, but services have not stopped. Actions have to be taken, and Julie outlined some of those. The bid for £27 million reflects the extent of the backlog and the gap between demand and capacity in the system. As it currently stands, for elective care, there is a shortfall of £85,000 for outpatient assessments and £25,000 for inpatient and day case treatments. A lot of that will be funded by the HSCB through additional funding. It will provide that to the trusts from its resources.

The bid would provide for almost 20,000 outpatient assessments and over 7,000 inpatient and day case treatments. The bid also includes £6 million for the diagnostic shortfall. At the end of July, the

waiting list for diagnostic testing was 14,000. The estimated gap between demand and capacity for diagnostics is around 2,000 for endoscopies and 55,000 for all other diagnostic testing. That bid of £6 million would enable over 50,000 diagnostic tests to be undertaken, which would significantly address the shortfall between demand and capacity. So there are new elements in it. Expenditure continues to be undertaken, and, as I say, the board will have to take action in some areas, which will impact waiting times.

Mrs Cameron: Just to clarify, if that bid is not met —

Ms Daly: If the bid is not met, we will have increased waiting times right across all those areas. We have already seen the waiting times for elective care increase over the last month. There had been an improvement between March 2012 and March 2013, but we are now seeing increasing waiting times. A whole combination of factors is contributing to that, and the board is looking at the issue. There is the demand/capacity issue and the gap, which the board is very focused on. The reality is that there is a real gap. Funding is needed, and if that is not provided, there will, without question, be increases in waiting times.

Mrs Cameron: It is a very grim outlook.

The Chairperson: What criteria were applied to decide on the rationale for shifting that priority from category C in June to category B?

Ms Thompson: Unscheduled care/patient flow and specialist services are in category A and are viewed as being absolutely critical to maintaining the hospital system and keeping it working through the winter. In the next batch — category B — service developments are planned, and we would love them to happen, including in elective care, but, if money is not available, they can be stopped. The final batch — category C — is about pay awards, money for pharmacy and cuts to ALBs. We, and, I am sure, the Minister, would love to have those in place, but priority has been given to other areas because they are about front-line patient care, which is always our priority. The choices are about what is absolutely essential to keep the hospital system going as we look into the winter. As I said, it depends on what level of resource is made available. It is not as simple as saying that you go down the priority list until the money runs out. At that point, the Minister will see what he can do across all the bids to meet the priorities and work through them in that way. Each individual bid has to be ranked as a totality.

The Chairperson: However, was it not absolutely critical last week when it was category C?

Ms Thompson: With the category C list, a lot of the expenditure was already on the ground, and we were looking at pressures right across the system. The difference is that this list has been prioritised based on uncommitted funds.

The Chairperson: I am sorry to interrupt, Pam. Are we now saying that hospital services are categorised ahead of community/prevention?

Ms Thompson: No. A significant element of unscheduled care/patient flow is to do with domiciliary care and community care. It is vital that domiciliary care packages are in place to enable patient flow to work across the system. Category A priorities are about maintaining the flow through the system so that we do not get blockages and that, as far as possible, people will flow through. It is not about hospital issues being "good" and community issues being "bad".

Ms P Bradley: I want to ask about two bids that have been submitted in the October monitoring round that were not in the June monitoring round. The first is a bid for £13 million and is categorised as "other departmental priorities", which is quite vague. What are these other departmental priorities? The second bid is for £18 million for pharmacy, which also did not feature in June. Where has that come from?

Ms Thompson: The bid for other departmental priorities is made up of a range of areas, and I appreciate that the title maybe does not help to convey that. We have uncommitted funds with grants to voluntary bodies; the family fund; money that we want to invest in regional support that we get from NHS Blood and Transplant and from Public Health England; medicines management; and a range of other priorities. Money has not yet been invested, for example, in domestic and sexual violence, in fractures or in nurse training. It is a combination of a wide range of uncommitted areas of expenditure

— hence the title— that are planned and that we would love to happen, but which are dependent on funding being made available. I am sure that members appreciate that they are important areas, particularly the grants to voluntary bodies and the support that is given to us by UK organisations. Difficulties will be created if we cannot fund the bids and do not receive the money. I apologise for the title, but I guess that it is all-encompassing.

You asked why they were not bid for previously. They were assumed to have been within the overall financing of the entire Department. We looked at ???it strategically and identified the pressures, and that is where the figure of £160 million comes from. We are saying that we do not have the money to make these payments between now and the end of the year, and we need to bid for that money for it to be financed. If it is not financed, it cannot happen. That is the difference between the two strategies.

Similarly for pharmacy, it is money that could be made available between now and the end of the financial year. If the funding is not available, decisions will have to be taken about that not happening. This goes back to the previous Minister's letter of 28 August, which lists the details of that. The bids are picking up from that and stating that we require funding to enable these things to happen between now and end of the financial year.

Ms P Bradley: I am glad that you explained that because these other departmental priorities are really important, and many of them keep our health service afloat.

There is an £18 million bid for pharmacy. Have you identified any emerging pressure over the past few months that would call for that amount to be invested?

Ms Thompson: We would love to put more investment into pharmacy. We have also been looking at community pharmacy remuneration, as we discussed last week in Committee. It is about recognising the fact that, if more money were available, it could go into pharmacy. We continue to keep an eye on what is going on in pharmacy. It is a big spend area. It is a recognition that we believe that we could invest £18 million between now and the end of the financial year. If the money does not come, we will not be able to invest it.

Ms P Bradley: It is good to have that. We are all being lobbied at the moment about Ask Your Pharmacist Week. We all live and work in our communities, and pharmacy, which is an integral part of the whole system, has been under immense pressure.

I have another question, and I do not know whether to be extremely happy or extremely worried about this. In this monitoring round, there is no bid for family health services, children's services or support at home, and I believe that they were all in category A in the June bid. Is it because things are going really well?

Ms Thompson: It means that the money is being spent. In one way that is good, but, equally, it creates pressure on the other side. Every single one of those areas has experienced an increase in expenditure, and that money is being incurred day and daily. Therefore, they are not on the bid list now, because we cannot do anything to stop them. They are already there.

Ms P Bradley: At least that is positive.

Mr Beggs: I read in the media that head of the Civil Service is likely to advise the Treasury that four Departments are breaching their expenditure limits. Is the Department of Health one of those?

Ms Thompson: At the moment, in 2014-15, we can technically break even: that is the way I would describe it. However, with that, a significant range of consequences are created. We are very concerned about our response to the head of the Civil Service that, whilst we can break even technically, the consequences for patients and clients — we are talking about having to close facilities and restrict hours — are very significant. Technically, we can do it, but the consequences are very significant.

Mr Beggs: Can you advise us about your expenditure profile? I suggest that, in the summer months, you do not spend as much as in the winter months, when there are all those additional pressures. How much have you overspent to date in the first six months of the financial year?

Ms Thompson: The trusts forecast that, if things continue as they are, they will be overspent to the tune of over £130 million. We need to look at what that will translate into and how to manage and control expenditure back down. We are doing that, which is a challenge. These proposals are stoppable, and that is how you break even, because you cannot stop existing expenditure.

Mr Beggs: Are you saying that about £130 million of expenditure would also have to be stopped so that it is not incurred in the second half of the year, apart from these other savings?

Ms Thompson: That is the forecast to the end of the year, and I guess that that is what is behind the figure work. You can understand the importance of taking urgent decisions. The ability to break even will reduce us, day by day, as we go forward.

Mr Beggs: It is quite serious.

Ms Thompson: It is very serious.

Mr Beggs: I see that there is a bid for £4 million in October for departmental running costs and arm's-length bodies, which did not appear in June. The paper explains that, in September, Minister Poots authorised a reduction of 2·5% to the running costs of the Department and some arm's-length bodies. Can you clarify why, such a short time later, the new Minister is bidding to reverse that?

Ms Thompson: What Minister Poots did was to say, as I think is the approach that is being taken across quite a few Departments at the moment, that we could not afford to wait any longer in signalling that a cut might be necessary. Organisations were advised to plan on the basis of that 2·5% cut, and told that, if money could be made available, the cut would be restored and the budgets increased. However, that is highly dependent on money coming back through the October monitoring round process to enable that to happen.

It is prudent to understand that, the more notice you give to an organisation, the more likely it is that it will be able to achieve that reduction. Organisations were advised to plan on the basis of a 2·5% reduction, and Minister Wells is saying that, if funding could be made available, those cuts could be restored again. It is not a change of approach and is consistent with the letters that were issued in line with Minister Poots's decisions.

Mr Beggs: Is giving people significant warning and time to implement mooted changes not indicative of a lack of forward planning?

Ms Thompson: That is why we took the decision to put them on notice. We asked them to plan for a 2·5% cut after we knew that the results of the June monitoring round had not materially changed where we were.

Mr Beggs: The Department of Health has total flexibility with its budget, but, if it wants to make new bids, they must be for major and unforeseen circumstances, and ICT licence renewals are listed. How could the need for computer software licences have been unforeseen?

Ms Thompson: ICT licences are a capital priority. We are the same as every other Department in how we deal with capital. The definition of "major and unforeseen" applies only to our revenue spend, not to our capital spend.

Mr Beggs: How have you not been able to plan that you need a software licence? Did you not know that you needed a software licence?

Ms Thompson: The major and unforeseen element does not apply to the capital budget. We are allowed to bid for any capital —

Mr Beggs: Why was it not already in your expenditure plans? Did you know you needed it?

Ms Thompson: It was not profiled in the capital budget.

Mr Beggs: I do not understand how it was missed. Can you explain why?

Ms Thompson: We had been looking at various options. I do not know whether Bill wants to comment on that in a bit more detail, but we had looked to see what was viable. We had looked at timings and whether this was going to hit in 2014-15 or not. That was the issue.

Mr Bill Pauley (Department of Health, Social Services and Public Safety): There are choices about which licence you might take, how long it might last and its relative value for money. There is an option whereby we could spend £2 million this year and simply renew the licence for existing software. With this option, we could renew the licence, upgrade the software and enhance the capacity of the system for mobile working. It is a bid that contributes towards our system's ability to work on a mobile basis.

Mr Beggs: How many bids have there been during this mandate? In how many of those monitoring rounds has the Department bid for something that is in the category of major and unforeseen circumstances?

Ms Thompson: We have bid in most monitoring rounds. We have not necessarily been successful in all of them and have had in-year monitoring money provided to us, which has been most helpful. I think that we have probably bid in each of the monitoring rounds, and a large portion of those bids has been for familiar stuff that we discussed with the Committee — for example, elective care, TYC and a range of winter and emergency pressures. They were similar to these October bids, but, as we go into 2014-15, the scale has increased considerably.

Mr Beggs: In how many of those monitoring rounds have the bids been for current expenditure?

Ms Thompson: Elective care and TYC can be looked at non-recurrently because you can start and stop large portions of that. Winter pressures can also be non-recurrent. There is no doubt that our recurrent level of spend has been increasing above the level of our available budget. That has gradually worsened as we have gone through the budgetary period.

Mr Beggs: Have we reached the stage in the planning process at which you have assumed, over these past years, that significant current expenditure would be achieved through in-year monitoring?

Ms Thompson: Certainly, the pressures are growing year on year, so the need for in-year monitoring money is significant. As we look at 2015-16, there will be a new Budget process for that year, and there will be increased pressures and a need to rely on further funds coming to us.

Mr Beggs: Do you agree that in-year monitoring is an unstable form of funding, is inefficient and can end up in bad decisions for your financial planning because you have limited choices?

Ms Thompson: I absolutely agree that it is less certain than having it in the budget from the start of the year. The Committee will be aware that, as we look at the financial year from last autumn time, things became exceptionally challenging from the Department's perspective, such that we ended the year with an overspend and so on, and we then rolled that forward into 2014-15. It would be very helpful if we could get money into a budget into 2015-16. I am not sure about the ability to do that, given the scale of pressures that are presenting across the piece for 2015-16.

Mr Beggs: Do you not agree that, in order to get the best value for money in the health service and the best service possible for patients, it would be much better to plan in advance and live with whatever that new increased budget would be rather than having this stop-go approach that we are seeing here today?

Ms Thompson: Certainly. Clarity for 2015-16 and having as many of our pressures covered as possible would make life a lot more straightforward.

Mr McKinney: I will touch on an issue that I thought might be a small one at the start, but it may, depending on your answers, be bigger. The June bid, as I understand it, was uncommitted funds solely. Is that right?

Ms Thompson: No. The October bid is uncommitted funds, and the June bid looked at pressures across the year.

Mr McKinney: Why, then, are wages in the October bid?

Ms Thompson: It is because they are uncommitted at this point. Those decisions have yet to be taken. If funding becomes available, the pay award can potentially be made. If funding is not made available, it would be stopped.

Mr McKinney: I needed to get that clear in my head.

Will you tell me how much you got from the pharmaceutical price regulation scheme (PPRS) in the first quarter of this year?

Ms Thompson: The only money that we got from the PPRS relates to the first quarter — January to March of the last financial year. We got £2·89 million or £2·9 million.

Mr McKinney: Do you expect to get that across the year, reflective of each quarter?

Ms Thompson: It is not yet exactly clear how much we are getting, but we would expect more funding to flow through to us.

Mr McKinney: Could it amount to something like £12 million?

Ms Thompson: We do not know, but it could.

Mr McKinney: What process are you getting that money through?

Ms Thompson: It initially comes through to the Department of Health in England, and then it comes back to us. Its apportionment among the various countries is still being worked through and has yet to be finalised, and it is a complex area. Ultimately, that will come through. It then sits within the pharmacy budget, because that will hopefully offset any growth in the pharmacy budget that would otherwise have been there.

Mr McKinney: Should we not simply subtract the potential £12 million from the £18 million bid you are making?

Ms Thompson: No. We have assumed that, because of the way in which the agreement is set up, any growth in our spend will be offset with that money. It is dampening down the growth in the pharmacy budget.

Mr McKinney: Are you saying that that PPRS money is going back only into pharmacy?

Ms Thompson: It is within the pharmacy budget. That is where it will go, because it is against the pharmacy spend. That is what it is set up to do.

Mr McKinney: I think that the public mind on pharmacy spend might be confused. Maybe I am talking about my own confusion rather than that of the public, but pharmacy, in my understanding, is the drugs end. Is it simply going back into drugs?

Ms Thompson: The cost of the drugs would be higher without that scheme in place, so it brings the cost of those drugs back down.

Mr McKinney: Just to be clear, you are saying that your bid, without that PPRS scheme, would be £12 million plus £18 million.

Ms Thompson: Yes, without the PPRS scheme, we would need more money, absolutely.

Mr McKinney: I would have assumed that you would subtract, given that it is new money and it is in this year, and you do not know exactly what it would have been, potentially — it is new money coming back to you, if you like.

Ms Thompson: Yes, but you are right in that, if we did not have it, we would be £12 million worse off than we are at the moment.

Mr McKinney: I want to look at another area. While all this pressure is going on, you are merrily recruiting at the board. As I understand it, you have got an increase of somewhere between 20% and 30% in board staff over the last two years. Can you explain that?

Ms Daly: You are right about the increase, and it is across a whole range of areas. Some of it relates to staff who are on fixed-term contracts and will not be permanent, and those contracts will cease. There is a range of areas where there has been increased work over recent years and staff have been taken on board to address those issues. We know that there has been a focus on this area, and the chief executive of the Health and Social Care Board has said that she will look at it.

Mr McKinney: How did you get to a state, against the backdrop of a moratorium on Civil Service recruitment and a flatlining on pay, of increasing your staff in the last two years, by whatever means, by 20% to 30%?

Ms Daly: I am sorry; I am not clear on it. However, the board is not made up of civil servants, so there has not been a moratorium on recruitment within the Health and Social Care Board, and there has been an increase in staff. In some of those areas, the work that is being taken forward is on a fixed-term basis; those numbers have been brought in and they will leave again. Nevertheless, you are right: there has been an increase of —

Ms Thompson: Just to clarify, there has been no moratorium on Civil Service recruitment either. Now, what needs to change potentially moving forward is a different thing. However, up to now, there has been no moratorium on recruitment.

Mr McKinney: I still have not heard an explanation of how you can justify an increase of 20% to 30% in your staff at a time when we are sitting here discussing huge pressure on budgets. You are looking after your board, and there is another 600 staff in the Department.

Ms Daly: It is absolutely important to be able to explain where there has been that increase —

Mr McKinney: Can we get an explanation?

Ms Daly: I hope that I can explain some of it to you. The increases have been right across the different areas within the board. There has been an increase in admin and clerical of —

Mr McKinney: You are pointing to the figures. What is the rationale?

Ms Daly: Staff have been brought on to the Health and Social Care Board to address some of the issues in Transforming Your Care, and that did not exist five years ago. Some of the staff in those areas are on fixed-term contracts, and they would be there for a year.

Mr McKinney: So, can you say that that represents the 30%? Is Transforming Your Care partially the answer?

Ms Daly: It is an element of it. There have also been increases in commissioning staff and integrated care staff, and there has been an increase in the area of social care and children's services. That is because of some of the increasing demands and the issues that need to be addressed there. I do not have further detail on that, but we are aware of the increases and where the areas are. We know that it is something that the Health and Social Care Board is looking at.

Mr McKinney: Do you understand how there might be a reasonable level of public concern when those figures are revealed to them? You guys are recruiting merrily while services to the public in general are not being delivered satisfactorily. In fact, you are recruiting and the service is worsening.

Ms Daly: It is absolutely important that, where there are increases, they are explained so that the public understand.

Mr McKinney: I am not hearing an explanation here.

Ms Daly: It is not a case of increasing staff for the sake of doing it. Changes are happening. We need staff to deliver some of the transformations and some of the increased statutory responsibilities. The Health and Social Care Board will go through a rigorous process to satisfy itself of the necessity for the staff. The chief executive has said that she will look at it. We are aware of the areas where there have been increases. It is not simply on the basis of an issue being likely to cause public concern that we look at the areas where there is increased expenditure to ensure that that is justified, but I absolutely —

Mr McKinney: You raised the issue. Is it justified?

Ms Daly: We have nothing to indicate that it is not justified, but we will look at it with the Health and Social Care Board.

Ms Thompson: The 2·5% cut applies to the regional board and our departmental budget. That is on top of a 4% cut that we have already been managing. There have been significant reductions on that as well in our departmental —

Mr McKinney: But your overall expenditure has gone up from some £21 million to over £25 million.

Ms Thompson: That is in the regional board —

Mr McKinney: So, you have increased your expenditure by £4 million or £5 million.

Ms Daly: The expenditure has increased in the board. It is absolutely right to be concerned about increasing numbers, but we have to recognise what the expenditure is there to do. I am picking out Transforming Your Care, but the area where there has been the biggest increase in the board is in children's services. That is because of the increased requirements on the board. It is essential to have the staff to deliver those. We cannot make the changes required without having the staff in place, so there has been a change in the requirements in the board. That is reflected in staff. We expect to see changes in those numbers moving forward, as, for example, the transformation is implemented. As I said, a number of staff are fixed term. We expect to see the numbers going down when their contracts end.

Mr McKinney: I just think that it is an issue of concern. There are 600 staff in the board, which is an increase of 20% to 30% in the last two years. The Department employs 600 as well. You are also talking about bringing in commissioners, ICPs and local commissioning groups. Is there duplication there?

Ms Daly: We are working to ensure that there is not duplication and that services are delivered in the best way. You mentioned the integrated care partnerships. They are regarded as an absolutely key element of Transforming Your Care. It is about bringing together a collaborative network of GPs, pharmacists and voluntary and community groups that cannot get together to properly inform the development of services and clear patient pathways. We see in front of us today the two bids that are going through for Transforming Your Care, which, if delivered, could make a significant difference, maybe not in cash-releasing savings but in the avoidance of future costs to the health service from stroke victims. That is just one example. The reality is that you need people to do that. We cannot do it without putting in place the arrangements to allow those people to get together to develop that work. The assessment of Transforming Your Care is that it is an investment to save. Those costs will not continue forever.

Mr McKinney: That is your perspective. What I see from my perspective — I meet a lot of different organisations — is that you have a Transforming Your Care plan; you have a deterioration in the provision of services over the last two years; you have a bloating of the board in administration terms by 20% to 30% and a £4 million to £5 million increase in expenditure. Somebody somewhere should come before the Committee and start answering questions about that.

Mrs Dobson: I take you back to questions that Kieran asked earlier about the pressures around the winter months. Looking through your summary of options, I see one short sentence about winter pressures. Catherine, you spoke about the flu vaccination, the GPs and how that has already begun. Can you give me your assessment of the services most likely to be under pressure? What steps will

you take to support staff to manage that demand? As we all know, staff are under so much pressure, and many are at breaking point. Will you outline that for me?

Ms Daly: Absolutely. There is a raft of issues aimed at addressing the pressures that the emergency departments will face in the winter months. There is also emergency department capacity planning because we recognise that, in order for the system to work effectively, there are capacity issues and that capacity planning is important. There is also 24/7 working. The health service is a 24/7 system, and we need to look at providing the funding to enable that to happen and also for the GP out-of-hours system. I think that we said, when we were giving evidence to the Committee last week, that if we look at all of these bids, we see that none of them actually stands alone. They are all related. When you look at unscheduled care and patient pathways, you see that all of that contributes to the effective running of not just emergency departments but effective discharges and the effective working of GP out-of-hours services. The GP out-of-hours services come under significant pressure at times of public holidays, for example. They take significant pressure off emergency departments. If we do not look at all of those elements, it is like squeezing the bubble. For example, not addressing the issues with GP out-of-hours services will put an increased pressure on emergency departments. That even goes to the elective care bid that we talked about earlier. We talked about the potential for extended waiting lists now. If we have people who are waiting for hospital appointments and their waiting times are longer, there is potential for that to increase attendance at emergency departments. There is a whole raft of issues. I could talk you through some of the actions that would be intended —

Mrs Dobson: Does that support the staff? Staff feel that they are not being supported. Even when they contact us, as elected representatives, they are saying, "Please do not let my name be used." They are afraid of reprisals. With the morale of front line staff being so low and the hours that they are working, it is at breaking point. Could you outline —

Ms Daly: Absolutely. I would repeat what the Minister has always said about the work that is carried out right across the health service seven days a week. Obviously, without the staff, we could not do it. The commitment of the staff is absolutely phenomenal. All of this is about supporting staff. It is recognising the pressure that they are under. It is trying to put in place the additional help to free up and give better provision and resources right across emergency departments. Also, as well as the funding that we are bidding for, as we mentioned earlier, the emergency department task group has been set up, which is chaired by the CMO and the CNO. Again, that is looking at how there could be more effective working in emergency departments in all aspects of unscheduled care. Right at the heart of all of that has to be the consideration of the impact that it has on staff.

Mrs Dobson: So, if you have this in place, I should see a reduction in the number of staff contacting me through the office about the pressure. If what you say is in place, that should —

Ms Daly: That is right. If we are able to put in place what is required, absolutely that should take the pressure off staff. Equally, if we are not able to put it in, that pressure remains.

Mrs Dobson: You say that your aim is to:

> *"Avoid admissions; improve patient flow; improve discharge arrangements; and enhance community services to support discharge."*

These are major challenges, which require investment to deliver the savings, as Roy outlined earlier. Were Northern Ireland Statistics and Research Agency (NISRA) statistics used to predict future population growth when the original 2011 budget was set? Obviously, demand is outstripping the budget.

Ms Thompson: Yes. We factor in demography and look at population growth through the piece. Equally, to use one example, the number of looked-after children is considerably higher than any population growth would ever have indicated. That may be to do with society. It may be to do with different children's issues that the Savile inquiry and things like that have raised. Pressures present that are on top of a demographic pressure. New treatments present that, again, increase expectations. People wish to see them funded. So, demography is an element, absolutely, of what we bring into the budget as we look at it, but it is by no means the end of it. The demand can most definitely outstrip that population-growth aspect.

Mrs Dobson: Kieran touched on this earlier when he started his questions; can you provide us with an update on the incident at the Ulster Hospital? I think that it is important that the Committee knows what internal escalation measures, I think you called them, were instigated at the hospital, including the impact on patients. We have had so many of these incidents with worrying impacts on patients as well as on the staff. Finally, what impact will the current budgetary position have on the future likelihood of dangerous incidents such as that which happened at the Ulster Hospital and across the board in hospitals?

Ms Daly: As regards emergency departments' performance, I can tell you certainly that the figures this morning indicate that there were no 12-hour breaches as we stand. The Health and Social Care Board is engaged with the various trusts on the issue. When there are exceptional issues, as has been the case with the South Eastern Trust, an escalation plan is put in place. The board will work with the trust to look at the reasons why that occurred, whether the escalation plan is effective and what measures need to be taken. All of that would be considered in the context of everything that is happening around the unscheduled care programme in general. I would expect that the task group will also take that into account in its considerations. At each stage when it happens, the board is very much engaged with the trust on the reasons for it and to ensure that escalation is effective and that any immediate steps that need to be taken in that respect are done.

I have just looked to see whether I had more detail. As I said, I know that certainly, this morning, none of the trusts across the system was experiencing any 12-hour breaches. The performance was not good in August. We certainly know that there were 142 12-hour breaches in the Belfast Trust. We know that, at the minute, all of the trusts are working on unscheduled care implementation plans. They are engaged with the Department and the task group in developing those plans to ensure that measures are taken to ensure —

The Chairperson: Sorry, Catherine and Jo-Anne. It is important, obviously with regard to our piece of work on monitoring emergency departments, but I do not want to get into the specifics of individual trusts or hospitals today. If you want to share useful information with Jo-Anne, that is fine.

Ms Daly: Absolutely.

The Chairperson: I want to remain on the key issue.

Ms P Bradley: I suppose that it can be brought up under any other business, rather than this item.

The Chairperson: Yes. We can come back to it. Are you OK with that, Jo-Anne?

Mrs Dobson: Kieran brought it up earlier, so I was just following on from that. Thank you.

Mr Dunne: Thanks very much for your input today. I understand that there was £10 million in the June monitoring round for clinical negligence. I see that it does not feature in the October bid. Are we improving on that? What measures are we taking to reduce the risk of clinical negligence? What are we doing to address issues that have been found?

Ms Thompson: It is not in the October bid because effectively that expenditure will be incurred. There is nothing that you can necessarily do in-year to prevent or stop it. The settlements will be made by the courts, and they are whatever they are. We need to cover them. Certainly we expect that expenditure in 2014-15 will be less than in 2013-14. The range of issues that we are looking at is to try to improve this for the future around the Quality 2020 agenda and to ensure that serious adverse incidents and adverse incidents are clearly understood, lessons are learned and people are treated appropriately through the various processes, such as the quality reports that come out from organisations about how trusts are getting on. All of that agenda is aimed at ensuring that clinical negligence will ultimately reduce and is looking at whether there are means of alternative dispute resolution and mediation. They would not impact in the six months between now and March; the period is simply too short. Therefore, it is not there as a bid because, effectively, the bid has been built up on the basis of where we could take decisions to stop or control expenditure, and hence it is not on the list for October.

Mr Dunne: So, those issues are taken seriously and addressed to stop recurrence of something that has happened.

Ms Thompson: Absolutely.

Mr Dunne: I have a couple of other things. EDs have been touched on, and there is a bid for £1 million. RQIA has carried out a review of unscheduled care. What will the impact be if you do not get that £1 million? How do you see that impacting on the continuous problem that we seem to have in the health service about EDs and how they respond to increased workloads?

Ms Daly: The impact would be that we would not be able to take forward and implement in full the RQIA recommendations. Throughout, the unscheduled care bid reflects the funding required for the implementation in substance of the RQIA recommendations. Therefore, if we do not get it, we would not be able to do that, and, clearly, that would impact on the ability of the emergency departments to deal with patients in a safe and effective way within the targets that have been specified.

Mr Dunne: So, it is a priority.

Ms Daly: It is absolutely a priority.

Mr Dunne: Are you reflecting to the Minister that it is a priority?

Ms Daly: We are; that is the advice, and it is categorised as top priority within the categorisation of the bids.

Mr Dunne: What about elective care? We touched on it last week. To me, it is a very serious issue involving £21 million. How do you see that within your priorities?

Ms Daly: It is categorised as category B for the reasons that Julie explained earlier. It is not that it is not important; all of this is critical. I would say that it is absolutely critical. The issue is that we already have 84,000 of a gap in outpatient assessments and 25,000 in inpatient day-case treatments. If we were successful with this bid, it would fund almost 20,000 assessments and more than 7,000 treatments. The board would then be able to address the rest of the gap. Effectively, this is the funding that would be required to enable patients to be addressed within the specified targets for waiting times. The waiting times have increased over recent months, and they are increasing further in current months. Without this funding, those waiting times will increase further. As I say, there is no element of this that can be looked at in isolation. An increase in waiting times has the potential to increase attendance at emergency departments —

Mr Dunne: It is critical that we get this funding of £21 million.

Ms Daly: It is.

Mr Dunne: We need £160 million. Could you keep the lights on with £100 million?

Ms Thompson: We are making a bid into the centre at £130 million, and, absolutely, £100 million would help to avoid the worst of the consequences. The list of things that would have to happen are effectively these bids at £130 million, and the more money that we can get against those the better in avoiding the consequences. They are all very high priority areas right across the system. We need urgent clarity about how much extra will come to the Department to allow us to invest it in the services between now and the end of the year. It is vital.

The Chairperson: On that point, Julie, some of the local media today indicated that the Minister commented that £60 million could take us through. Where did that figure come from?

Ms Thompson: I think that the £60 million is on top of the £20 million on the presumption that £20 million would be received. It is an unofficial number, but one that is in the public domain around discussions at Executive level. It would not be appropriate for me to comment any further on Executive discussions.

The Chairperson: So, the advice on the £60 million would not have been advice from you.

Ms Thompson: Obviously from our perspective, the more money that we can get the better. Ultimately, it is a matter for the Minister about how far down the list and how much money he believes is necessary to make the decisions as we move forward and make the investments that we need.

The Chairperson: Thank you for your attendance. I think that it goes without saying that we all recognise the strains and pressures within the system. However, I am very clear that the information that I have heard today has not satisfied me. We were told in the June monitoring round that £160 million was needed that was critical. We were then told that it was £140 million, which then became unfunded pressures, which, last week, we were told was an overview of the current financial situation.

Now, this week, we have a bid for £130 million; we have found £10 million; and we cannot be clear on where the £20 million that is conditionally allocated will be spent. As far as I am concerned, I see a policy shift in where some of these priorities now lie. We are looking at a very different document this week from the one that we looked at last week. I think that we need to highlight things such as the policy focus shift on issues such as TYC.

We are seeing a big shift from a £21 million bid in June to a £2·6 million bid on the key component, the key plank of what we need to deliver health. It is a huge shift. The principles of shifting left means that the public health bid of £10 million has gone to £3·5 million. Somebody, somewhere, has had a shift in priorities or focus, and I am not satisfied, as Chair, with what I have heard today. It does not give me confidence. This is not about rejecting bids; this is about us, as a Committee, doing our job and being able to stand over a robust piece of work going forward with confidence, and I have not heard that today.

Ms Thompson: I can assure you that there has been no shift in strategic focus. The list of the bids reflects, purely and simply, the amounts of money that are not invested yet, between now and the end of the financial year, and for which we require additional funding. That is how the bids have been put together.

The moves between June and now — for example, in the public health one that you point out, £5 million of the difference has already been invested in vaccination. It is not a policy shift; that money has gone into public health as was originally intended. That is part of what is creating the £140 million gap. Yes, we have managed £10 million of that to create the bid of £130 million. The bid is shaped around where there are effectively choices as we look forward. Either money becomes available and they are financed, or money does not become available and they are not. That is where the difference in the amounts are. The priorities are the same as they were before.

I know that that is complex, and the budget most definitely is complex, but the reality of these October monitoring bids is that they are all around areas where we can take choices and stop expenditure. It is a factual reality as opposed to where you would want to stop expenditure or anything of that nature. It is simply, therefore, to the Executive to say, if money could be made available, here are the areas that would be able to be continued. That is the difference: it is not about a policy shift from one to the other; it is simply referring to the factual reality of where we are at this point in time with six months to go before the end of the year.

The Chairperson: In response to that I say that we have been given clear examples today and we have presented you with clear examples of where there has been a shift in priorities. Bids have been produced in this round that were not included in June's. It is not appropriate or correct to say that it is the same list going forward. It is certainly not, and we have highlighted a number of them: the pay awards; the ALBs costs —

Ms Thompson: Again, because those are areas where a choice can be made because the funds are not committed, they are on the list simply and purely because they are factually where money can be stopped — where a pay award can either be issued or not, where an ALB cut can either happen or not. That is why they are on the list. It has gone right across the budget, and the entire analysis there behind the bids is around the issue of where choices can be made. We are asking the Executive to consider whether funding should be provided to allow those services to continue, and that is where they are. That is a completely factual analysis of what remains to be spent between now and the end of the year. If we do not get the funding, those will have to all stop.

The Chairperson: OK. Thank you — all three of you — for your attendance today.