

**FROM THE MINISTER OF HEALTH**



Mr Philip McGuigan  
Chair  
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Dear 

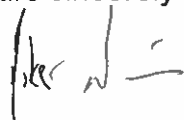
A Finance briefing session with the Committee has been scheduled for 19<sup>th</sup> February 2026.

The evidence session will be attended by:

- David Keenan, Interim Finance Director.
- Nicola Shields, Interim Head of Financial Planning.
- Paul Montgomery, Investment Director; and
- Catherine Fitzpatrick, Head of Capital Resources Unit.

In advance of this session, I attach a briefing paper for the Committee detailing the impact of the proposed draft Budget for 2026 -29/30 on the Department's Resource and Capital budgets.

Yours sincerely



**Mike Nesbitt MLA**  
**Minister of Health**

## 2026-29 Multi-year Resource Budget

### Forecast Requirement

- Table 1** below sets out the departments total forecast expenditure requirement for the 3-years 2026-29 that was included within the DoF Multi-year Budget 2026-29 Information Gathering Exercise. This assessment shows a total shortfall of **£1,081.3 million** in 2026-27 after reflecting an estimated **£86 million** Immigration Health Surcharge Income.
- The overall financial shortfall incorporates the funding gap carried forward from the 2025/26 financial year, and includes provision for the 2025/26 Pay Awards, 2026/27 Pay, National Living Wage, Real living Wage and Non- Pay Inflation.
- While this may seem like a large ask when we take account of the funding gap carried forward from 2025-26 this requirement is in line with our normal growth and inflationary increases of some 4 to 6%.

**Table 1: Forecast Expenditure Requirement**

	2026/27 £m	2027/28 £m	2028/29 £m
<b>2025/26 recurrent expenditure (including full year effect of 2025/26 investments)</b>	8,309.6	8,309.6	8,309.6
Executive/HMT Earmarked Pressures (excluding waiting lists)	14.4	17.2	17.3
Inescapable Pressures (including inescapable WLI)	671.8	846.8	1049.0
Pay 25/26	221.0	221.0	221.0
Pay 26/27-28/29	188.5	382.6	582.6
<b>Total forecast expenditure requirement to maintain existing services</b>	<b>9405.3</b>	<b>9,777.2</b>	<b>10,179.5</b>
Budget Baseline Position	8,223.6	8,223.6	8,223.6
Immigration Health Surcharge	86.0	91.0	94.0
Anticipated Executive/HMT Earmarked Funding	14.4	17.2	17.3
	<b>8,324.0</b>	<b>8,331.8</b>	<b>8,334.9</b>
<b>Funding Shortfall</b>	<b>1,081.3</b>	<b>1,445.4</b>	<b>1,844.6</b>

4. In addition to submitting bids for the funding gap above the department also submitted a number of high-priority bids to support the Reset Plan and to deliver the Minister's strategic vision for Health and Social Care.
  
5. We know that to deliver this level of reset, without a significant level of new investment will require a clear focus on those areas that will make the most impact. The department are also aware that the constraints on investment may mean the reset will take longer to achieve. These high priority bids are listed in **Table 2** below.

**Table 2 High Priority Bids**

Priority	Category	Bid Title	2026/27 £m	2027/28 £m	2028/29 £m
1	Primary Care Reform	Primary Care Reform Including General Practice Reform and Neighbourhood Health Model	12.3	19.5	24.5
2	Social Care Reform	Family & Children Policy and Domestic & Sexual Abuse	8.8	23.6	32.0
3	Social Care Reform	Reform of Adult Social Care including Implementation of the Adult Protection Bill for NI	30.1	91.2	121.5
4	Digital	Digital Including: (A) Infrastructure Programme Team, (B) Digital Workplace Programme Team, (C) Regional Data Archiving Programme, (D) GP Order Comms, (E) Digital Dictation/Voice Recognition, (F) Independent Sector Access Enabling Project	3.0	6.5	6.4
5	Workforce	Workforce including Education/Training, Stabilisation and Transformation	45.4	60.0	52.8
6	Acute Services / Trust Services Reform	Urgent & Emergency Care-including HSC111 Regional Telephone Triage Service. implementation of Neurology Review. Reshaping Stroke Care Action Plan	19.7	71.0	84.6
7	Mental Health Reform	Mental health reform - Implementation of Mental Health Strategy 2021-31	9.5	13.9	18.4
8	Improving Health and Addressing Inequalities	Improving Health and Addressing Inequalities	4.0	6.0	11.0
9	Secondary Care	Diagnostic Capacity Imaging & Pathology Services	12.0	12.0	12.0
<b>Total High Priority Bids</b>			<b>144.8</b>	<b>303.6</b>	<b>363.1</b>

6. Since the time of the DoF Multi-year Budget 2026-29 Information Gathering Exercise, we have revised our assessment of the additional funding requirement for 2026-27 in line with the current 2025-26 financial position. Our latest assessment of the additional funding required in 2026-27 is some **£865 million**, as shown in **Table 3** below.

**Table 3**  
**2026-27 Revised Projected Funding Requirement**

	£ million
Remaining 2025-26 Funding Gap (carried forward excluding pay)	90
2025-26 Non-Recurrent Savings (excluding Trusts)	155
Funding reductions (excluding elective)	66
<b>2025-26 shortfall brought forward (excluding pay)</b>	<b>311</b>
Pay 2025-26 and 2026-27 (2026-27 at 2.5%)	390
Price inflation at 2% (currently running at 3.8%)	50
National Living Wage (central range projected 4.1%)	40
Real Living Wage (differential to National Living Wage)	50
Pre Commitments	10
Additional GP Funding	14
<b>Total Projected Funding Requirement 2026-27</b>	<b>865</b>

7. While work is continuing to reduce our funding gap in 2025-26, we are still forecasting an overspend in the current financial year. With other departments also projecting an overspend, the Executive are seeking agreement with Treasury that the repayment of the overspend can be deferred over the 3-year budget period. However any overspend deducted from our 2026-27 budget will add to our already constrained financial position.

### **2026-29 Draft Resource Budget**

8. You will be aware the Finance Minister has published a draft multi-year budget to set resource budgets for 2026-27 to 2028-2029 and capital budgets for 2026-27 to 2029-2030.

9. While the Finance Minister advised it was not possible to provide any department with the funding it requested the proposed budget represents an extremely disappointing outcome for Health, albeit perhaps an unsurprising one given the limited amount of funding available for allocation.

10. In summary the Finance Minister is proposing funding to Health as follows.

- **Reinstatement of £165m, £165m, £165m** Waiting Lists and Elective Care which was in our 2025-26 allocation
- **£63.2m, £210m, £368.5m** General Allocation
- **£26m, £19.5m, £nil** Autumn Budget Consequential
- **£12.4m, £13.5m, £13.5m** Graduate Entry Medical School (GEMs)
- **£3.6m, £3.7m, £3.8m** Windsor Framework (Treasury earmarked)
- **£11.6m, £16.7m, £25.3m** Transformation (Treasury earmarked)
- **£1.9m, £3.7m, £3.8m** EU Match Funding

11. While it's welcome that the **£165m** waiting list funding has been reinstated as it's essential to cover inescapable pressures for red flag and time critical patients, and to build essential capacity within the system, health would require the certainty of this being allocated to our baseline recurrently.

12. The funding provided for GEMs, Windsor Framework, Transformation and EU Match Funding will only cover our existing commitments and will not provide extra capacity to deliver more.

13. When we take account of the proposed additional general allocations (**£89.2m**) included in the draft budget in 2026-27 this leaves a net funding gap of some **£775.8 million**.

14. Given the limited additional funding provided as a general allocation, for 2026/27 at least we will have to generate funding internally through savings and efficiencies to cover our inescapable commitments, which will include pay awards.

15. Based on current financial planning assumptions we will require cash releasing savings somewhere between 10% to 14% to be generated to cover our projected funding shortfall in 2026-27 for only the most inescapable pressures.

16. Delivering savings of this magnitude in a single year is not feasible and therefore, we will seek agreement on a recovery plan over the three-year budget period. This

would allow managed delivery, though it remains exceptionally challenging and not without risk.

17. The department have produced a new Strategic and Operational Planning Guidance document, which sets out clearly an expectation that HSC Trusts, ALBs and the DoH boards must set out and agree plans before the start of the new financial year based on two possible scenarios of a 6% reduction and a 12% reduction in expenditure, along with showing how they will deliver a series of actions and expectations for improving service delivery and delivering the Reset plan throughout 2026/27.
18. These plans are due to be received by the end of February and once agreed these should enable HSC Trusts, ALBs and the department to detail what the necessary actions would be to meet those two financial scenarios beginning on 1 April.
19. However, we should stress that the department does not believe it's possible to deliver a balanced budget within a single year and we will continue to request a multi-year recovery period to achieve a balanced budget position by the end of the multi-year budget. Currently we could not assure our Minister that we could deliver a 12% reduction within this timeframe.

### **2026–30 Draft Capital Budget**

20. The DoH capital priorities notified to DoF in September 2025 for the four-year Budget process totalled **£3.0billion**. The Finance Minister has proposed allocations totalling **£1.8billion** for DoH across the Budget period, 2026/27 to 2029/30, as set out in Table 1 below. Although the average Capital DEL allocation of **£458m** each year across the next Budget period is higher than the allocation for the current financial year of **£391m**, the General Allocation for other capital projects covers only 52.9% of the bids made. The bids for Flagship, City Deal and Inclusive Future Fund projects were met in full.

**Table 1: Draft DoH Capital Budget 2026-30**

£ million	Budget 25	Draft Budget 2026-30				
	2025/26	2026/27	2027/2028	2028/2029	2029/30	Total
General Allocation		354.0	315.0	305.0	310.0	1,284.0
Flagship		104.1	137.8	145.5	139.4	526.8
City Deal/IFF		5.0	9.1	5.4	3.6	23.1
<b>Total</b>	<b>391.0</b>	<b>463.1</b>	<b>461.9</b>	<b>455.8</b>	<b>453.0</b>	<b>1,833.8</b>

21. The proposed capital funding allocation will allow DoH to meet its inescapable pressures such as the New Children’s Hospital Flagship Project and to formally commit to some of the previously partially committed projects (£435million funding requirement over Budget period) albeit with some delay. There would be no scope to fund new projects or those for which a funding commitment has not previously been made. However, the specific details will depend on the final Budget outcome with additional uncertainty given that the Executive did not agree to the Draft Budget proposals.

22. Although the proposed 2026/27 allocation is larger than for the other years, a high proportion of the funding required for this financial year relates to inescapable pressures with the potential for these costs to rise from the forecasted figures at September 2025. For example, the inescapable pressures in respect of ICT projects are expected to increase significantly. The experience of 2026/27 would also suggest that additional inescapable capital pressures will emerge which implies that it would be prudent to set aside some funding as a reserve rather than allocate all the available capital funding at the start of the year. Table 2 below shows that only **£5m** is expected to be available for non-inescapable pressures in 2026/27 compared with an average of **£48m** in the subsequent 3 years. This table is based on the draft Budget figures and the pressures may be subject to further change before the final profiles are agreed.

**Table 2: Summary of Implications of proposed Draft Budget 2026-30 outcome for DoH Capital spending plans**

£million	2026/27	2027/28	2028/29	2029/30
Flagship*	101.9	139.6	147.9	119.8
Inclusive Futures Fund / City Deal	4.9	11.8	3.1	3.6
Contractual Commitments	33.6	11.7	11.5	5.7
ICT Committed Schemes	142.4	31.1	36.5	87.0
Maintaining Existing Services	174.4	198.4	181.4	179.3
Receipts	(19.0)	(19.0)	(19.0)	(19.0)
<b>Total Inescapable Pressures</b>	<b>438.2</b>	<b>373.6</b>	<b>361.4</b>	<b>376.4</b>
<b>Draft Budget</b>	<b>463.1</b>	<b>461.9</b>	<b>455.8</b>	<b>453.0</b>
Reserve/additional ICT funding	20.0	50.0	40.0	25.0
Funding available for other pressures	4.9	38.3	54.4	51.6

\*There have been some changes in the funding requirements for Flagship, City Deal and Inclusive Future Fund projects from the bids submitted in September which is the reason for the differences between the figures in Tables 1 and 2. Although there is expected to be further change it should be noted that the funding for these projects is earmarked so that any reduced requirements in a given financial year will be returned to DoF rather than being available for other DoH capital projects.

23. Subject to Executive agreement to the draft Budget proposals, work will be taken forward on the development of the DoH 10-year Capital Investment Plan which will set out the projects that are expected to be funded over the next decade, subject to confirmation of funding and business case approval. This will provide DoH ALBs and business areas with the assurance needed to allow them to take forward the projects included within the plan.



Northern Ireland  
Assembly

Committee for Health

# OFFICIAL REPORT (Hansard)

January Monitoring Round and Three-year Budget Plan:  
Department of Health

19 February 2026

# NORTHERN IRELAND ASSEMBLY

## Committee for Health

January Monitoring Round and Three-year Budget Plan: Department of Health

19 February 2026

**Members present for all or part of the proceedings:**

Mr Philip McGuigan (Chairperson)  
Mr Danny Donnelly (Deputy Chairperson)  
Mr Alan Chambers  
Miss Órlaithí Flynn  
Miss Nuala McAllister  
Mr Colin McGrath  
Mr Alan Robinson

**Witnesses:**

Ms Catherine Fitzpatrick	Department of Health
Mr David Keenan	Department of Health
Mr Paul Montgomery	Department of Health
Ms Nicola Shields	Department of Health

**The Chairperson (Mr McGuigan):** We welcome from the Department David Keenan, interim finance director; Nicola Shields, interim head of financial planning; Paul Montgomery, investment director; and Catherine Fitzpatrick, head of capital resources. You are all welcome. Thank you for coming. We got a written briefing, so I will hand over to you for some brief introductory remarks.

**Mr David Keenan (Department of Health):** Thank you, Chair. I will start by making a few opening remarks to provide an update on the current resource budget and the 2026-29 multi-year Budget, and I will then hand over to Paul to cover the capital position.

First, when it comes to the current year's budget, when I briefed the Committee in December, I advised that, despite delivering significant savings this year, the Department will not be able to break even. We are on track to deliver in excess of £300 million of savings, and we were projecting an overspend of £200 million. You will be aware of the recent allocation of the reserve claim. The Department received £185.4 million, which will reduce the overspend considerably, but it will remain a challenge to break even. However, the Department is making every effort to achieve that by year end.

You will be aware that the Finance Minister published a draft multi-year Budget in early January, with proposed resource budgets for 2026-29 and capital budgets for 2026-2030. Although the Finance Minister advised that it was not possible to provide any Department with the funding requested, the proposed Budget represents a disappointing outcome for Health, albeit not a surprising one, given the limited funding available for allocation by the Executive, particularly in 2026-27. To put it in context, the proposed level of additional spending on health in Northern Ireland included in the draft Budget is now projected to be at a 10-year low, compared with that in England. It also sees funding for health fall

even further behind the 4% to 7% premium above England that, the NI Fiscal Council estimated, may be necessary to take account of the higher levels of need here.

During the multi-year Budget process, we submitted bids to cover all our additional costs and to meet future years' pressures, such as pay and inflation — all the additional pressures that come as a result of increasing demand on services. We also submitted high-priority bids to support the Department in delivering our reset plan. It was welcome that the proposed draft Budget allocation reinstated the £165 million waiting list funding. It also proposed funding to cover our commitments to continue to roll out the multidisciplinary teams and the funding for the graduate medics at Magee. However, we require the certainty of the waiting list funding to be allocated to our baseline recurrently, as it is essential to cover inescapable pressures in red-flag and time-critical patients and to build capacity in the system.

In order to cover the 2025-26 pay commitments and meet our Minister's priorities for 2026-27 pay around the real living wage and other inescapable pressures, we require, as you will see from our briefing paper, additional funding of £865 million. Against that, the draft Budget has proposed additional general allocations in 2026-27 of £89 million, which will leave a net funding gap of £776 million. Given that position, we will have to generate funding internally through savings and efficiencies to cover those inescapable commitments. In order to break even in 2026-27, we will require cash-releasing savings of somewhere between 10% and 12% to be generated. Delivering savings of that magnitude in a single year is not feasible. Therefore, we will seek agreement on a recovery plan over the three-year Budget period, which will allow a managed delivery of that, although it will still be exceptionally challenging and not without risk.

The Department has produced a new strategic and operational planning guidance document that sets out clearly an expectation that all our arm's-length bodies (ALBs) will agree plans before the start of the new financial year based on two possible scenarios — a 6% reduction in spend and a 12% reduction in spend — along with showing how they will deliver a series of actions to improve service delivery and deliver the reset plan throughout 2026-27. Those plans are still being progressed, but, once they are agreed, they will enable the Department to detail the necessary actions to meet those two financial scenarios, beginning at the start of the financial year. Again, however, I stress that we do not believe that it is possible to balance the budget in a single year, and we will continue to request a multi-year recovery period in order to achieve break-even.

I will now hand over to Paul, who will cover the capital position.

**Mr Paul Montgomery (Department of Health):** Thank you, David. As regards the in-year capital position, two bids were submitted as part of December monitoring. A bid of £5.5 million for backlog maintenance was fully funded and was used to address issues such as electrical remedial works and fire risk assessment works, including fire door replacements, roof repairs, boiler replacements, insulation, window replacements, ventilation upgrades and exterior works. The second bid was only partially funded, with £19.7 million allocated for IT hardware, including funding for the replacement of 17,000 laptops and 14,000 desktop computers. Significant capital investment is planned for the fourth quarter of the financial year, which is not unusual. That is being actively managed in order to minimise the underspend.

For future years, the Department of Health submitted capital bids with a combined value of £3 billion as part of the Budget process, which will cover a four-year period — 2026-27 to 2029-2030 — for capital departmental expenditure limit (DEL). In December 2025, the Committee was advised that the Department expected to receive between £1.6 billion and £1.8 billion in capital funding over the next Budget period. The draft Budget proposals published by the Finance Minister in early January 2026 were at the upper end of what we expected, with £1.8 billion of capital funding available. Approximately £0.5 billion of that funding is earmarked for Department of Health flagship projects, primarily the new children's hospital, with the remaining £1.3 billion representing a general allocation to be used at the Department's discretion.

Although we expect to have record levels of capital investment funding available, we also have record capital funding requirements. The proposed capital budget for general allocations will allow us to fund just over half of the bids that we made for the next four years. That means that we currently expect to be able to meet most of the inescapable pressures but have limited scope to progress partially committed projects and no scope to take forward projects that have no form of commitment to date from the Department. The intention had been to develop a 10-year capital investment plan for the Department of Health based on the draft Budget position in order to provide a degree of certainty on the funding for individual projects. However, in light of the lack of Executive agreement on the draft Budget position and the scale of the capital pressures identified by other Departments, there remains

significant uncertainty about the capital allocations that will be agreed for the Department in the final Budget. The work to take forward the capital investment plan will continue when a Budget position has been agreed.

I am happy to take questions.

**The Chairperson (Mr McGuigan):** Thank you very much. There is an awful lot to unpack there. I have a list of questions, which is probably like the Department's budget: it is an overspend, so I will have to reduce it. You said that, although the £400 million eases the pressure, you still expect an overspend this year.

**Mr Keenan:** At the minute, if we take the reserve claim into account, what we reported to the Department of Finance in the most recent forecast out-turn would leave a net £26 million overspend. We see some movement on that, and there have been further savings. I expect that to come down. We will do a new forecast in 10 days' time that will go back to the Department of Finance. I expect that £26 million to have fallen, but we will be able to confirm savings at that point. That should be down.

I would not say that we do not think that we can break even at the moment. We are making every effort to break even. We will have to see how we get on over the next couple of months, but the figure is definitely coming down.

**The Chairperson (Mr McGuigan):** I will make some general budgetary points before I get into specifics. There are a number of scenarios. There is a draft multi-year Budget that can be approved or changed or there may be no agreement on it. You are pointing to a stark scenario for Health if there is not a multi-year Budget. I imagine that that would be catastrophic for the Department of Health.

**Mr Keenan:** That is why we believe that, by delivering the savings of 6%, we can cover a lot of them as inescapable pressures. There is also a belief that the Department can get to that level, and, if so, it would facilitate a recovery over the whole multi-year Budget period. If you could deliver that saving of 6%, you would obviously have to add to it in the following two years and build on that 6%. However, if we cannot get that multi-year Budget agreement, as I have said, we would be unable to balance our budget in a single year. If they take that single year in isolation, we could not balance the budget because it would need savings of something like 12% to do so.

**The Chairperson (Mr McGuigan):** Obviously, the key to delivery in Health is the staff, and the Minister has given a commitment that he will prioritise staff pay when he gets the budget. He has also prioritised the minimum living wage for the social care sector. We all welcome that, but will it depend on a multi-year Budget?

**Mr Keenan:** It remains the Minister's commitment. How we fund it will be the difficulty. At the minute, in the planning guidance that is out for consultation with all the arm's-length bodies, there is a directive — I should say that it is in draft and is likely to be amended — that puts those assumptions in place for next year. We have to find the funding to cover the pay award that was agreed only this year and will be paid in February and to fund the Minister's commitment on 2026-27 pay, the national living wage and the real living wage. All those commitments are stated in that document, and that is where we need to get to. It will be challenging to cover all those commitments.

**The Chairperson (Mr McGuigan):** We will keep our fingers crossed that we get an agreed multi-year Budget.

What about capital projects? We had the Northern Trust at Committee and a number of us raised the issue of Birch Hill. When you were last here — I think it was you — at one point we had a conversation about the 14 projects that were put on pause. Birch Hill is one, and, off the top of my head, there is also the children's unit at Altnagelvin. There were 14 projects. Within the allocation that you talk about, Paul, are those 14 projects the priority, leaving aside the hospitals at the Royal Victoria site?

**Mr Montgomery:** The Royal Victoria Hospital is part of the inescapables. The partially committed would be funded out of whatever funding is residually available. Some £200 million is available for allocation, and the cost of those partially committed projects over the budget period is £435 million. Obviously, we will have to prioritise and delay some of those projects, simply because it is not affordable to take them forward in line with the original time frames.

**The Chairperson (Mr McGuigan):** Are you saying that even the 14 projects that were paused will have to be prioritised?

**Mr Montgomery:** Yes.

**The Chairperson (Mr McGuigan):** Will the prioritisation take the form of shifting deadlines, or is it that they will or will not happen?

**Mr Montgomery:** It is about time scales, so some of them will need to be delayed for one, two or three years.

**The Chairperson (Mr McGuigan):** OK. Again, I think that we had a conversation with you about the earmarking of the money to reduce waiting lists. A lot in Health requires an awful lot of money, but all of it should be spent in improving patient outcomes, and there is a commitment to that. In the £215 million that was earmarked in this Budget, what will we see for reducing waiting lists?

**Mr Keenan:** In the multi-year Budget, we will have £165 million this time.

**The Chairperson (Mr McGuigan):** Is that per year?

**Mr Keenan:** Yes, per year. That £165 million is a flat figure for each year. Some £85 million of that is, basically, for red-flag and time-critical patients. That is already in our 2025-26 budget, and we anticipate that that will be fully spent. That will be a recurring need of the Department to basically maintain that and make sure that people with red-flag and time-critical referrals are seen when required. The other £80 million out of the £165 million is to build capacity in the system. At the minute, £11 million of that is committed from actions that took place in 2025-26. There are still plans to be developed for the balance of the £80 million.

Obviously, nothing has been agreed, but the difference between the draft Budget and last year is that, last year, we had flexibility on part of that £80 million. The current draft Budget does not propose that flexibility. Again, it is only a draft. If the Budget were confirmed, the Department could develop plans to utilise the balance of that £80 million. At the minute, as I said, £10 million or £11 million is already committed from actions that took place last year.

**The Chairperson (Mr McGuigan):** This is my last question. We are discussing legislation today, and we discuss strategies and adopt motions weekly in the Assembly on strategies that look really good on paper but are without money to invest in them. When we discuss legislation, we are concerned that we pass it but cannot fund what must be done to implement it. I assume that there is flexibility in the three-year Budget. Are there initiatives to invest to save, so that we see the transformation in our health service that we talk about daily and so that, after three years, there will be a hell of a lot more progress in efficiencies and transformation that produce better outcomes?

**Mr Keenan:** I cannot really go into specifics at the minute, but you see how difficult our budget is. The Department really needs to invest now in anything that we can to save for the future. We need to see the big picture. The planning guidance is out to consultation. ALBs have been tasked with coming up with plans as to what they could do. They have also been given directives as to the direction in which the Department wants to go. That planning guidance builds on the reset plan and the Minister's three-year plan. It factors in such things as the neighbourhood model, more investment in the community and voluntary sector and so on. Once we can see the whole picture, things like invest to save can be considered.

At the minute, the focus is very much on 2026-27, because that year is so bad. The focus is on what we can do in that year, though the Department is still looking at this as a three-year plan or process.

**The Chairperson (Mr McGuigan):** The Department of Finance has a five-year plan, so I hope that the Health Department looks at how its financial commitments in the next year and the next two after that fit into the five-year plan. However, I understand completely the constrained financial scenario that you are in.

**Mr Keenan:** We had developed a five-year plan in line with requests from the Department of Finance that very much followed the reset plan and the three-year plan. It was based on what was bid for at the

multi-year Budget exercise. That plan was with the Minister, but it now needs refined and tweaked to reflect where we are now.

**Mr McGrath:** Thank you for the presentation. I still say that the toughest Department is Health, and the toughest branch in it is the one looking after the money. Therefore, thank you for detailing just what there is not.

My question is about the savings that you require trusts to make. If they make £50 million in savings this year, does it mean that next year they do not get that money at all, or does their baseline go back up to what they got at the start of the year and have the capacity? Is it just reduced out of their budget?

**Mr Keenan:** The assumption is that the savings that they have made this year can be delivered recurrently.

**Mr McGrath:** If that saving is found through a reduction in service provision, is that just a reduction in service provision going forward?

**Mr Keenan:** Similar to what we are doing at the moment, trusts would have been asked to develop savings plans. The Department would have been trying to protect front-line services. There were a number of proposals. Even this year, we tasked the trusts with such a difficult ask, but proposals came forward. However, because of their impact on services, they were not taken forward. The Minister is on record as saying that he would not implement saving measures if they were going to have such an impact on services. Our assessment is that the savings that they have delivered to date have had a minimal impact on service provision. That is the instruction that trusts have been given by the Department.

**Mr McGrath:** I know that you say that with the best intentions, but, when we meet the trusts, they tell us that they have no money. They have been asked to make cuts, and you have to wonder how they can find millions and millions of pounds' worth of cuts. They must be doing millions and millions of pounds' worth of stuff that is not really impacting on patients.

I do not know sometimes whom to believe. Is it you saying that they can make cuts without impacting on patients, or is it the trust saying that it has no more money to cut? Then you wonder where the cuts are coming from. Is there some secret place where they spend money that they do not need to spend and can then make cuts when you ask them to without it impacting on patients? Any chief executives whom we meet tell us that the money that they have is being spent on patients, on delivering operations and maintaining hospitals.

**Mr Keenan:** Their argument would be that they have done all that they can. The Department's position is that we can still do things better and more efficiently. The focus is on care for elderly people, patient flow and things like that. The Department sees a lot of things like that that cost the system money and make it inefficient. Those are the areas that trusts will be asked to focus on.

**Mr McGrath:** It is scary to think that they are so inefficient that they are wasting millions of pounds every year. As you said, if they make efficiencies, they can make savings. One year, the trusts saved £50 million. It feels weird that they spend £50 million inefficiently each year.

**Mr Keenan:** I am not sure that I would use the word "inefficiently". I would say that there are things that they could do better.

**Mr McGrath:** That does not improve it much, but I get your point.

You are going to ask arm's-length bodies to undertake a 12% cut. When I was a councillor, I sat on the board of arm's-length bodies that were asked, at one stage, to consider a 3% cut, and they were sweating because of the impact that that would have on what they did. If we ask for 12%, it is four times that figure, which will be four times the sweat for some of those organisations. I suspect that, over the past five to 10 years, they have probably been asked at different points to make cuts. Is there a fear that, when you ask them to undertake such large cuts, they reach a tipping point and, effectively, will just become incapable of delivering the service that they are there to provide?

**Mr Keenan:** Some of the smaller ALBs went through that exercise, and we see that they are at the point where they will not be able to deliver anything. Our budget is £8.6 billion, and the gap is 10%, which is why we are suggesting savings of 6% and 12%. We are allowing for the fact that certain parts of the Health and Social Care (HSC) system will not be able to deliver savings. Unfortunately, that will put pressure on other areas to make that up.

To go back to the point that the Chair raised, we think that 6% is achievable across the system. The impact of 10% or 12% on services would just be too severe.

**Mr McGrath:** That means that there is 10% or 15% less work that, for example, the Patient and Client Council, which I sat on, can do, which, in turn, means 10% or 15% fewer patients getting help and assistance. That is worrying.

Finally, I have been on a wee bit of a rant over the last while about buildings. Some £251 million of high-risk works need to be done. You said that you will have up to about £1.2 billion for capital: how much of that will be able to address the £250 million of high-risk works that need to be done?

**Mr Montgomery:** Some £115 million of spend on backlog maintenance has been factored into that. In addition, there will be £200 million of general capital allocations for trusts to spend on minor capital works. It will not address all of it, but we are trying to make progress. Obviously, we could spend more if we had more budget. To come back to the Chair's question, we could spend more, but then there would not be any money for partially committed projects. We need to strike a balance in allocating the funding available.

**Mr McGrath:** I will bank that as "fairly good". If you can give £100-odd million and there is £200 million available across the trusts, that will, hopefully, address the lion's share of the backlog.

I do not know whether it is the use of the phrase "high-risk", but, as an entire institution, we are meant to look out for patients, buildings and other things. When you hear that that level of high-risk maintenance work needs to be done, you think about the patients on those premises today and what is not working. Are the sockets not working? Are the fire alarms not working? It is not ideal.

**Mr Montgomery:** As I said in the opening statement, the money that we give for backlog maintenance will be spent by trusts on roof repairs, window repairs, updates and those sorts of things. Those are the highest-risk things that they will look at. I think that they will look to ensure consistency between trusts in what they record as serious risk.

**Mr McGrath:** OK. That is grand. Thank you.

**The Chairperson (Mr McGuigan):** In the last conversation that we had with the Northern Trust, it told us that it will need, I think, £25 million or £28 million over the next five years for Holywell Hospital's maintenance. It is ridiculous. I just make that point.

**Mr Donnelly:** I was also about to make that point. It is a false economy. If you do not build a new facility, you will have to spend £28 million over the next five years on the upkeep of a facility that was built in the 19th century. It makes no financial sense.

I appreciate the bind that we are in. It is horrifying. It is a really shocking situation. That difference between one year and three years is incredibly concerning. I am sure that the ALBs were incredibly shocked when they were told to make plans for cuts of 6% and 12%. I take Colin's point: some of those organisations, which deliver important services, may not be able to function. We are in a really concerning place.

I certainly encourage the Minister to take seriously the pay uplifts that staff are due and to factor those in at a very early stage. On the real living wage, there was a lot of trust broken and a lot of hurt caused among healthcare staff when they did not get their uplift at the same time as those in the rest of the UK and when the U-turn on the real living wage was made in September. I really encourage the Minister to resolve that, because I know that there was a lot of hurt among healthcare staff, who are under a lot of pressure to deliver services.

I have couple of questions, and the Chair has touched on a few of them. Can you give any update on whether a decision has been made on car parking charges and how much it will cost?

**Mr Montgomery:** Not taking the decision will cost £7 million a year, which is not built into the figures that David talked about. We are waiting —

**Mr Donnelly:** The understanding is that there is no further decision to be made; it will go ahead.

**Mr Montgomery:** We do not know whether a decision has been made. As David set out, there is a large funding gap. We are looking at options to bridge that gap, one of which is deferral of the abolition of car parking charges, which was due to take effect from May 2026. A decision was due to be made soon or else we would not have the time to go through with it, because, obviously, we would need to go through the legislative process.

Basically, I think that we are reaching the point where, even if there were a decision to defer the abolition of car parking charges, we could not do so. We are at the stage now where we could not pass the legislation. Of course, if a decision is made, the Committee will be the first to hear.

**Mr Donnelly:** I am not sure whether you will be able to give us an update on this: we were recently told that the maternity hospital may be opened on a phased schedule. Have you any idea what services will be available and when? Is there a time frame?

**Mr Montgomery:** We simply deal with the money and —

**Mr Donnelly:** Fair enough.

**Mr Montgomery:** — money has been allocated, and it includes money for remediation to facilitate the earlier opening.

**Mr Donnelly:** With the allocation for primary care reform, to what extent have GPs been involved in discussions with the Department?

**Mr Keenan:** As far as I am aware, discussions are ongoing on that. There is a meeting due to take place in March to progress it. An offer went out to them in, I think, November.

**Mr Donnelly:** There have been ongoing discussions around that, then.

**Mr Keenan:** Yes, because they will be very much part of the neighbourhood model too, so the Department is keen to move that on.

**Mr Donnelly:** Thank you.

**The Chairperson (Mr McGuigan):** Back to the question that Danny asked about the maternity hospital: Paul, are you saying that there is money set aside for a potential phased remedial opening of that? That is news to us.

**Mr Montgomery:** A small amount of funding has been bid for as part of flagship projects for the design works for the water redesign and for remediation.

**The Chairperson (Mr McGuigan):** Can you tell us how much that is?

**Mr Montgomery:** It is £4 million.

**The Chairperson (Mr McGuigan):** OK. Is it your understanding that that money could allow for some parts of the hospital to be opened sooner than the two years that we initially heard?

**Ms Catherine Fitzpatrick (Department of Health):** We will have to wait for the outcome of the initial redesign of the water remediation, which will determine the full cost of that. That will probably determine the stages at which the hospital could start to open.

**Mr Montgomery:** I am not saying that it is remediation works in general that will facilitate — I am not saying that, if that funding is made available, it will definitely open. There is a large number of issues at hand in determining the phased opening of the facility.

**The Chairperson (Mr McGuigan):** OK.

**Mr Montgomery:** That work will support it, but it will not determine it.

**The Chairperson (Mr McGuigan):** OK. Thank you very much. That has been useful. I appreciate it.