Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

June Monitoring and 2013-14 Provisional Out-turn: Departmental Briefing

28 May 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

June Monitoring and 2013-14 Provisional Out-turn: Departmental Briefing

28 May 2014

Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Ms Catherine Daly	Department of Health, Social Services and Public Safety
Mr Seán Holland	Department of Health, Social Services and Public Safety
Dr Liz Reaney	Department of Health, Social Services and Public Safety
Ms Julie Thompson	Department of Health, Social Services and Public Safety

The Chairperson: You are very welcome, Catherine, Julie, Seán and Liz. You are familiar with the Committee and the format here. We ask for a presentation of approximately 10 minutes, and then it will be open to members' comments. Julie, I am not sure whether you are leading on this.

Ms Julie Thompson (Department of Health, Social Services and Public Safety): I am, yes. Thank you, Chair, for the opportunity to provide evidence to the Committee today on the Department's forecast out-turn for 2013-14 and its participation in the June monitoring round.

As we previously reported to the Committee, 2013-14 was an exceptionally challenging year financially for Health and Social Care (HSC). Indeed, that was reflected in our approach to January monitoring last year, in which bids of some £65 million were submitted to address the pressures that we were facing at that stage. Every effort was made to address the financial challenges during 2013-14 while maintaining the quality and safety of services. That included implementation of low-impact contingency measures in trusts and examining all aspects of the Department's budget to secure available savings opportunities. There was also extensive engagement with key stakeholders across the HSC and DFP. You will be aware that the Department participated fully with the 2013-14 in-year monitoring rounds and secured additional funding of £55 million for the revenue budget. Unfortunately, despite those measures, the Department is anticipating a cash overspend of some £13 million in 2013-14, which is approximately 0·29% of its budget.

I will now outline the Department's proposed approach to both the current expenditure and capital investment expenditure for June monitoring. In determining our approach to current expenditure, we

have considered a range of factors, the most significant of which is the financial context for 2014-15. As outlined in the briefing paper that was sent to the Committee on 29 April, the Department faces a considerable financial challenge in 2014-15, with some £160 million of additional resources estimated to be required to balance the books. Of that £160 million, £115 million of the deficit is rolling forward from 2013-14. Much of that deficit was dealt with during 2013-14 through non-recurrent measures, and it included additional allocations from the in-year monitoring rounds and the managed slippage and deferral of expenditure. The remaining deficit for 2014-15 relates to new service developments, which are essential to sustain current policies and to provide new cost-effective therapies. Together with cost pressures, such as pay, and demographic changes, those total some £305 million in 2014-15. They are offset by £90 million of Executive funding and £170 million of further savings. That is also set out in the briefing paper. That group of factors represents an additional net pressure of £55 million.

Financial deficits are projected in all five integrated trusts in 2014-15 due to front line service pressures in a range of areas. The Department, the Health and Social Care Board (HSCB) and the trusts have been working closely to identify opportunities for delivering both cash-releasing and productivity improvements totalling some £170 million in 2014-15. Those are in addition to the £490 million of savings that were already achieved in the three years to 2013-14. Unfortunately, despite the additional Executive funding of £90 million and the demanding savings plans of £170 million, we still have a funding gap of £160 million. That means that we are submitting a significant number of bids in the June monitoring round. You will see that those bids, which, again, are set out in the June monitoring briefing paper, total some £160 million and are primarily directed towards delivering a range of critical front-line health and social care services for patients and clients in Northern Ireland. For example, there are substantial bids that relate to unscheduled care and emergency admissions, elective care and specialist services, such as drugs, cath labs and cancer services. We are also bidding for Transforming Your Care (TYC) transitional funding to enable progress on the implementation of transformation, as well as for clinical negligence pressures, which are inescapable.

The bids will be used to ensure that key services can continue to be provided to some of the most vulnerable, including children, the elderly, and mental health and learning disability clients. In short, they are essential to sustain the long-established policies and principles of health and social care in Northern Ireland, where healthcare is predominantly free at the point of use and not limited by predefined exclusion of various therapies.

Turning to capital expenditure, DFP has advised that capital expenditure bids in this monitoring round must be for projects that can be fully spent in 2014-15, and they must not carry a tail into 2015-16. We have reviewed the planned capital expenditure for 2014-15, and, in line with routine processes, we have already reallocated any identified slippages and projects to other priority areas that can spend in year, including general capital, ICT and equipment. In that context, and given the significant constraint to ensure that there are no tails in the projects into 2015-16, no capital bids will be submitted in June monitoring.

In conclusion, the scale of the projected funding deficit in 2014-15, after additional funding and the delivery of significant savings, clearly indicates that it is not possible to fund a number of critical service pressures from within existing budget allocations. Our proposed bids will help to ensure that there is no detrimental impact on front line health and social care services. We, therefore, strongly recommend that the Committee and the Executive consider these bids favourably. We are happy to take questions from members on any issues.

The Chairperson: OK, Julie. Thank you for that. In the overall context, I am conscious of the Executive's agreement on additional in-year flexibilities for health, which is very welcome. However, it had been stipulated:

> *"current expenditure bids should not be tabled by DHSSPS, unless in the event of 'major and unforeseeable circumstances'".*

Can you assure the Committee that all those bids, which total £160 million, are for major or unforeseeable circumstances?

Ms Thompson: Absolutely. You are quite correct in your analysis of the approach to monitoring rounds in the Department. The bids are certainly major; I think that their size points that out. Equally, in the context of unforeseen circumstances, they reflect changes that were unforeseen from the setting of the Budget in 2010. It goes back to that period. As the Committee is well aware, we have

made bids through in-year monitoring rounds over the past couple of years, most notably in January monitoring, when we made bids of £65 million. Working forward into 2014-15, this is just building on that. I am sure that the Committee will have a degree of familiarity with a lot of the bids, because we have discussed them before in previous monitoring rounds.

The Chairperson: In a similar vein, I appreciate that the bids have been prioritised and categorised this time. We have had many a discussion about that. I am thinking about things such as the transitional funding for Transforming Your Care, which, all of a sudden, is categorised here as a (c), which ultimately means that:

> *"These pressures are not contractually committed and could therefore be scaled back to within available resources."*

In everything that we discuss and are informed of about Transforming Your Care, we hear that that was the great hope and that there would be a shift left with everything that that would bring. So, how can we justify that and the fact that the transitional funding, which is for a three-year programme that it was indicated would cost £70 million, has now become a category (c)?

Ms Thompson: I think that the Committee recognises that all our bids have high priority. You are absolutely right: we have had discussions about the difficulties of prioritising those bids in the past. The only reason why the bids at the bottom have been categorised (c) is that they are not contractually committed, so they could, in theory, be stopped, should resources not be made available. A lot of the bids ahead of that relate to expenditure that will be incurred and will have to be financed. That is the only distinction between them, but in the Department's opinion and, I suspect, that of the Committee, each and every one of these bids is of a high priority. It is very difficult to pull one bid out above another. The only reason why they are at the bottom is because they can be scaled back, if necessary, to live within the budget that we have. That does not apply to a lot of the other bids that are higher up the table. However, it in no way reflects any diminution of the priority of Transforming Your Care.

The Chairperson: I remain to be convinced about that, Julie. While you could argue that TYC is not contractually committed, it has been mandated and endorsed and is the framework within which we are about to deliver a new health and social care service. That suggests to me that we need to get the framework and the transitional funding right. A lot of these other issues will then flow from that. It should be further up the pecking order.

Ms Thompson: Yes, and all the other issues, such as the demands in children's services, domiciliary care and specialist services for unscheduled care, are presenting in the trusts. I think that every single one of these bids is exceptionally compelling in terms of the costs and the pressures that apply in the trusts as we speak. Therefore, it is very difficult to say that one is more important than another. Ultimately, the Executive will decide the priority of these bids. We will put the bids into the Executive system, and it will be up to them to decide. They are entitled to move bids around and could do that based on what they agree to fund, if they agree to fund any. So, that is the ultimate deciding factor.

The Chairperson: We have had this conversation with the Department on a number of occasions. Each Department has its priorities — or they should have a list of priorities. How much of the £70 million that was suggested for transition has actually been secured?

Ms Thompson: We have secured £28 million: £19 million two years ago and £9 million last year.

The Chairperson: So, is there a severe shortfall?

Ms Thompson: At the moment, the bid that we have on the table is £21 million for 2014-15. We got a lot less in 2013-14 than we bid for; we bid originally at £28 million, and we received £9 million. The figure of £21 million reflects what we believe is necessary in 2014-15, and we may need to bid again in 2015-16.

The Chairperson: Of a projected spend of £70 million over a three-year period, we have secured £28 million, and we are now saying that the bid for £21 million is at priority (c), as opposed to being at the top of the list. Is that giving an indication that Transforming Your Care is at risk?

Ms Catherine Daly (Department of Health, Social Services and Public Safety): Could I maybe pick that up? It is really important to emphasise to the Committee that there is absolutely no diminution of Transforming Your Care as a priority. It is a major and key priority for the Minister, and that is absolutely up front.

Julie talked about the distinction. It is about making that legal distinction. That is because there are contractual commitments for which expenditure has already been incurred in other areas, so it is simply not possible to stop those. Strategically, you would argue that it is not possible to slow down Transforming Your Care in the interests of delivering high-quality, safe and effective services. That is what the whole programme is about. So, I think that it is really important to emphasise that.

I take your point about the £70 million and the original profile. We had said that, as plans are rolled out, there is a possibility that the profile will change. That is part of what you are seeing here. It is not saying that the £70 million is not required. Overall, the Transforming Your Care programme is a three- to five-year programme and was always intended to be, although we were looking at the projections over the three-year budget period at that time. It is critical, however, and right across the service, actions are being taken to implement it. The purpose of this bid and its various categories is to ensure that implementation can continue to progress. That is one of the real difficulties, because if we do not get the funding for Transforming Your Care, faced with all the pressures across the budget, it will impact on the progress of implementation.

The Chairperson: In my view, that suggests that you prioritised it over a number of other things.

Mr McKinney: Where does this leave Transforming Your Care? As I see it, you looked for £28 million in June last year, and you got £9·4 million. In January, you got £7 million, although that may have been for a three-month period. Did you not get £7 million?

Ms Thompson: We got a total of £30 million from in-year monitoring in January, none of which went to Transforming Your Care. It went to children's services, safety and quality of services, unscheduled care, domiciliary care and elective care at the time.

Mr McKinney: I am trying to work out the maths. I thought that you got £7 million.

Ms Thompson: You are absolutely right. The £9 million in June monitoring went to Transforming Your Care, and that was added to the £19 million that we got the previous year. That makes £28 million in total. That is the money that has gone into Transforming Your Care to date. We want to build on that with another £21 million bid.

Mr McKinney: What are the chances of you getting the £21 million?

Ms Thompson: We put our bids into the DFP system, and we will see what comes out the other side. It will be dependent on the Executive.

Mr McKinney: However, furthering the point about the prioritisation, and given that the response that you got last year was £9·4 million of a £28 million, your expectation this year will certainly be lower.

Ms Thompson: I will come back to the same point: I guess that all the bids are high-priority bids, and the only distinction between them is that we can pull some of the expenditure down on Transforming Your Care. We will wait to see what the Executive will decide on money and on the prioritisation of where those resources go, and after that, we will have to reflect on what happens next.

Mr McKinney: You cannot make the decisions on implementation and transformation if you do not have the funds.

Ms Thompson: Yes. We have to live within the resource that we have; you are absolutely right.

Mr McKinney: Where does the Transforming Your Care plan stand against that doubt or vulnerability on funding?

Ms Daly: Fearghal, I am not trying to be awkward, but there is vulnerability in any area if we do not get the additional resources. That is the case right across the piece. So, if we do not get these

resources, Transforming Your Care will not be able to progress at the pace that is deemed necessary, and that will have a detrimental impact moving forward.

Mr McKinney: As we stand, is this still a three- to five-year plan?

Ms Daly: It is a three- to five-year programme, and we will look at how the budget changes over that five-year period to see whether there is any scope to progress in situations where there had been a slowing down in the programme. You cannot easily predict it at this point, and that is because of how resources change.

Mr McKinney: Are you admitting that there is a slowing down of the programme?

Ms Daly: I am saying that there could be. The programme is resource dependent; we need the resources.

Mr McKinney: By implication, inference or fact, the process must be slowed down now, because you got only £9·4 million of a £28 million bid and nothing in January, and there is now the potential that, in June, you will get less than you want.

Ms Daly: A whole combination of things is involved, such as the pace of progress in some elements of implementation being slower than originally envisaged. That happens in any strategic plan such as this. If we do not get the funding that is deemed necessary — we believe that these are realistic assessments of the required resources — it will inevitably impact on the pace of progress.

Mr McKinney: Given that there is a category of bids that are not contractually committed, some of the processes are obviously going slower than others.

Ms Daly: If it is not contractually committed, the funding is not currently in place and the commitment is not made legally at this point in time.

Mr McKinney: So, this is slowing up.

Ms Daly: It would —

Mr McKinney: As we sit today, the whole process has slowed up.

Ms Daly: It would be wrong of me to say that the whole Transforming Your Care process has been slowed up, because there has been significant progress across a range of areas. However, to progress it as intended, we need the funding that has been identified.

Mr McKinney: Is it possible, Chair, to ask for some indications about what is not moving off the starting line and what is halfway up the starting line?

Ms Daly: The £21 million bid is made up of a number of different elements.

Mr McKinney: That is not the point. In general, what is the position on Transforming Your Care? That will allow us to make considered judgements on these things.

The Chairperson: There is some information in today's pack about progress on the 99 proposals. I know that a number of members want in on this, but I suggest that the cost of the transition has altered somewhat from the £70 million.

Ms Daly: The £70 million was the estimate at the time that Transforming Your Care was published.

The Chairperson: Has it increased?

Ms Daly: In overall terms, we do not have an estimate that increases the £70 million. However, its profile has changed in how it has spread across the years. So, that is what is different. I am sorry that I do not have the original profile in front of me. The profile now is reduced in the first three years

compared with the original profile. Overall, at this stage, the total of £70 million over the three- to five-year period is still required.

The Chairperson: A couple of members have indicated that they want to comment on this issue.

Mr Beggs: I just want to go back to what was said about the original budget. You said that those pressures were unforeseen. Was the fact that health service inflation is much higher than ordinary inflation not foreseen several years ago?

Ms Thompson: I guess that, where the outplaying of demand is concerned, I would point to the considerable movement in 2013-14 and obviously to our visits to the Committee in September and December, when you were made aware that the trusts were experiencing, really for the first time, significant deficits that could not be managed. That has put us in an unforeseen place. Up until 2013-14, the Department's position was that it could be managed. That has been shown in our provisional out-turn numbers. Unfortunately, in 2013-14, that was no longer the case. So, the demands and expectations have increased. Combined with that, I guess that our ability to take out savings has also become harder and harder. That is because, as the Committee may be aware, those savings go on one year after another after another. So, the combination of pressures and savings drives out our current deficit. We put in bids of £65 million in that order in January monitoring. That was a completely new approach for 2013-14.

Mr Beggs: When I looked at last year's June monitoring round, I saw that the total resource bid from all Departments was £179 million. In fact, £80 million was distributed to all Departments. How realistic is your bid to get £160 million from in-year monitoring?

Ms Thompson: I guess that that is predominantly a question for DFP to answer. There is no doubt that there is significant pressure across the block in 2014-15. There will be challenges in dealing with all those pressures, from wherever they come. The Executive will need to consider all bids when they go through. Bids are due with DFP at the end of next week. The Executive will then need to consider at that point how those bids are best managed. There is no doubt that there will be significant pressures on the block in 2014-15, and the Executive will consider later in June how those are managed.

Mr Beggs: If you do not get £160 million, is the health service in crisis?

Ms Thompson: If we do not get £160 million, the first question to answer is how much we will get, where that therefore leaves us and what we can do to manage with those resources. The paper on the 2014-15 position sets out for the Committee the types of issues that are to be dealt with, and those are really the only things that the Department can do to manage its budget. If there are no additional resources from the Assembly, you are looking at the Department having to reprioritise and the Minister having to look at what he can do with the resources that he has. We still have to achieve the savings plans that we have already assumed that we are achieving at the £170 million. So, those are assumed to be achieved to get to the £160 million deficit. You are then looking at such things as what other impact there could possibly be. That is why, where the bids are concerned, if you can scale back expenditure for the likes of TYC or elective care, those are the types of things that will need to be considered. However, the options are relatively limited and are difficult to implement. They involve looking at the services that we currently provide to see whether more savings could be identified. They are all set out in the paper for the Committee, and we will need to reflect on that after the outcome.

Mr Beggs: You mentioned pressures on elective care. I notice that, of your £30 million bid for elective care, almost half — £14·1 million — is for orthopaedics. A constituent has made me aware of someone who has had to wait approximately a year for a hip operation. That is against an 18-week target from referral to treatment in the rest of the United Kingdom — certainly in England. If they do not get the £14·1 million for orthopaedics, will the waiting list for hip replacements extend beyond a year?

Ms Daly: Taking the hip replacement target, all of the targets are clinically driven, and that is a key target where there is a lot of focus. There had been significant progress in the hip fracture target over recent months but, obviously, again, in terms of the funding that is required for orthopaedic —

Mr Beggs: You talk about hip fracture but it is someone just needs a hip because the joint is worn.

Ms Daly: Sorry, hip replacement; right. There is significant pressure in this area. As you say, orthopaedics makes up a significant part of this bid. If we fail to secure the additional resources here, that will impact on the waiting list. It is difficult to say the extent to which it would impact because, overall, the extent of the gap in elective care is 76,000 assessments and 28,000 treatments. That is the gap that has been identified in demand and capacity by the board.

A significant level of that will be dealt with by the Health and Social Care Board through use of its own resources. In fact, the funding identified under this bid would be required to address 28,000 assessments and 11,000 treatments of that backlog. Clearly, if it is not secured, although the board would be able to make some inroads into some of the waiting list, this is a significant amount and they will not be able to deliver on the ministerial targets. They will be working to keep as close to those as possible but they need this funding to deliver on the targets.

Mr Beggs: How soon after the June monitoring round will the Department be able to determine what action it has taken?

Ms Thompson: As I understand it, we obviously need the Executive decision on the June monitoring round first and foremost, which I think is expected at the end of June. Then, it will depend on looking at where we are at, the level of resources that we got, and for the Minister to consider what happens next. So, I guess it will partly depend on how much we get and how challenging or otherwise the position is. Having said that, the later on you go through a year, the harder it is for any Department to manage its position as it moves ahead.

The Chairperson: The other point that somewhat alerts me — or alarms me, even — is that we talk about the £15·25 million capital that is going to be returned to DFP and that £10·45 million relates to the Royal children's hospital and energy centre. First, I am asking for clarification on what the energy centre is and, secondly, I am asking specifically why the children's hospital project has been delayed, and, if money is being returned, is the entire project now effectively at risk?

Ms Thompson: No, I can assure the Committee that it is not at risk. This is a timing issue, going into the 2014-15 year. It is a significant amount of resource but, equally, the scale of that project is £223 million in total, so it is a significant project. What the £10 million reflects is from the original assumptions of what we could spend within the 2014-15 year. Because it is a ring-fenced project and deliberately done that way, we are not able to use those funds on other projects, therefore the money has to go back to the Executive.

The energy centre is on the Royal site and is effectively to upgrade the energy facilities for the entire Royal site. That has to happen at some point with respect to expansion on that site and to support the services there. So, it is an essential element, effectively, of the redevelopment of the Royal in its entirety.

On your general point and your concern; the slippage on this does not mean to say that the project is in jeopardy. It remains on schedule to be completed in the same time frame. It will just kick off slightly later than originally intended, and this is impacting on the 2014-15 year.

The Chairperson: What do you mean by slightly later?

Ms Thompson: It will be completed by 2021, which was the original intention. That is my understanding.

The Chairperson: So, surrendering £10·45 million will not impact on that. You can give absolute assurances to the Committee that this is about timing and that there will be no delay or risk to the project.

Ms Thompson: That is our assumption at this point as we look at it in the very early days of the project. We will give the money back, but we are not expecting there to be any impact on the project itself and we expect that it will still move ahead. Ultimately, it would be a decision for the Executive if something different were to happen, but there will still be expenditure within this year, which kicks off the project and gets it off and running. It will just be slightly later than what was originally intended.

The Chairperson: Can we seek that information by way of assurances in writing to the Committee around the timelines being on schedule, effectively, and that there is no risk?
Mr Beggs: As part of the development of the new children's hospital, there is a new scanner, which has already been delayed. Is it being further delayed with this announcement of £10 million of capital not being spent?

Ms Thompson: I do not think that it is impacted by this proposal.

Mr Beggs: Can you come back and clarify that?

Ms Thompson: I can certainly clarify that.

Mr McCarthy: Chair, you used the term "alarmed" about what we have been hearing. Last week, we used the term "horrified" when we got the letter from the Department about what we are discussing today and the huge deficit there was.

We are currently talking about 2014-15. On the last page of last week's information, we see that the 2015-16 pressures are estimated to increase to over £317 million. So, we are talking about a real crisis in the health service as things stand at the moment. Despite your best efforts to try to convince us otherwise, I cannot see any way out of this. I heard Catherine's response to someone about the consequences. Again, in that paper, you say that, if sufficient funds cannot be met, then access to waiting times will be compromised. This Committee and all of the Northern Ireland community are crying about waiting times as things stand, and Catherine has confirmed that that will be the consequence if we cannot get even some of this out of this monitoring round. That is horrendous. That is dreadful.

Ms Daly: To absolutely clarify that, Kieran, I am saying that, given the resources and given the pressure, it is likely. I cannot say that it will be definite. It will depend on the decisions that are taken in light of the resources, but, clearly, there is a pressure, and, clearly, it is likely to be impacted.

Mr McCarthy: The waiting list is bad enough, but, worse still is that the safety and quality of services provided to patients and clients may be compromised. So, you are saying again that patient safety will be compromised if you cannot obtain the £160 million that you are looking for. That is a crisis, surely.

Ms Daly: Patient safety is the key priority in every decision that the Minister takes on the allocation of funding, and, in the position that will be at the outcome of this, patient safety will be at the forefront of any decisions taken.

Mr McCarthy: If that funding is not forthcoming, patient safety will be at risk and compromised. That cannot be acceptable to this Committee or to anyone who is trying to provide a first-class service through the National Health Service.

Ms Thompson: As Catherine said, the Minister has been very clear that the safety and quality of services is paramount in his decision making. It says that it may be compromised, and we and the Minister will need to look at what resources we get and, therefore, where the priorities go. He will take the safety and quality of care very much to heart in those decisions.

Mr McCarthy: Let us hope so. The last time, I think in the September monitoring round, you did not get the amount of money you bid for. Are you expecting something similar here? Are you expecting to get £160 million, as requested here, to cover all of these?

Ms Thompson: We have put forward what we believe to be very realistic and yet essential bids into the DFP and Executive system. Ultimately, it will be up to them to decide what happens and, in doing so, they will consider our pressures alongside those of other Departments. However, as to the bids that we have put forward, we will have to see what comes from the June monitoring round and then reflect at that point. If we do not receive all the resources that we have bid for, it will be very hard to see that the Department would be able to sustain all that it is currently doing; in fact, it would not.

Mr McCarthy: That is shocking in itself. If you cannot get this funding, patients will have to wait and their safety will be compromised.

Going back to the Transforming Your Care funding that I talked about earlier, you are still pushing ahead with that, and yet you have no guarantee of the funding. It seems to me that it is a case of robbing Peter to pay Paul just to keep someone from saying that we are not in crisis. That cannot be right.

Ms Thompson: At the moment, we are working through the processes that have been set up to identify where we have pressures. Those are being logged through and we wait for that outcome. We will need to see what happens next at that point, but as the paper sets out for you, none of these options are easy. If the money is not found from the centre, the options within the health budget per se to be able to budget for this are very limited.

Mr McCarthy: So, in conclusion, what we are hearing today is that if this funding is not forthcoming, our constituents, all of our constituents throughout the length and breadth of Northern Ireland, will be at risk. We sincerely hope that £160 million will be forthcoming.

Mr Dunne: The list of priorities includes a bid for £22 million to deal with unscheduled care and patient flow. It is categorised under the rationale as being "a". Does that mean that we are committed to it and is the money already spent or committed in some way? Does it include trying to address the ongoing issues at the Royal Victoria Hospital, for example? Is that included in this programme?

Ms Thompson: I will start on that and will ask Catherine to come in.

We have made a bid for £22 million. The Committee is aware that there have been unscheduled care pressures and, in fact, we made a bid for £11 million in the January monitoring round last year. There are significant pressures there and that reflects the need to effectively sustain the demands that are present. Emergency admissions have increased, and we need equally to ensure that patient flow is maintained across the entire hospital system and into community care. The pressures are about dealing with people who present to emergency departments, but they are also about the wider system and whether resources can go into both the hospital side and the community side to address unscheduled care.

Mr Dunne: The fact that this is categorised as "inescapable" means that this money has to be found; and it needs to be put in place to try to address this issue that we hear so much about. It is a priority day in and day out. Every week, it is in the media and we are all sick, sore and tired of it. It needs to be addressed and we need to get to the bottom of it.

Ms Daly: You are absolutely right. It is a critical issue and it needs to be addressed. The unscheduled care bid is made up of a number of elements, and those different elements are about a whole-systems approach in bringing in additional staff in the emergency departments and medical admissions units. This is about ensuring a better flow of patients. Elements of the bid are in relation to seven-day lab services to ensure that systems do not slow down over the weekend and that the system continues to operate seven days a week.

Another part of this bid is for £11 million for winter pressures. This is about effective planning. It is about saying that, at this stage, we know that this funding is needed, the various elements, to ensure that the system works effectively; that there are clear patient flows; that there are no blockages in the system; and recognising, based on historical trends, that, over the winter months, there will be severe pressures on the system that we need to plan for now. That is the totality of the unscheduled care bid.

Mr Dunne: Winter pressures come up annually, so why are they coming in under an additional bid?

Ms Daly: The non-recurrent funding is required to manage the increased demand during the winter months and that is based on the latest assessment that is over and above what is available in the budget that was agreed, and also to address pressures that were unforeseen due to increased emergency admissions. I do not have the statistics here, but we can see that there is a clear increase in the number of admissions and attendances at emergency departments.

Mr Dunne: Just to recap then, this is £22 million. If we are speaking to our colleagues, we need to emphasise the need for this funding to be pushed through.

Ms Daly: Absolutely, yes.

Mr Dunne: It is necessary to try to address this recurrent problem at A&Es, mainly in the Royal in the Belfast Trust, and in the Ulster Hospital as well, which is now continually under pressure. It is important that we focus on that funding.

Let me move on to a couple of other issues. We hear a lot about public health, and we are all very supportive of prevention. Funding is required for cancer campaigns, for example for ovarian cancer campaigns and others. Will money be earmarked for that within the public health budget? Is that to be a part of the £10·5 million additional funding?

Ms Thompson: As I understand it, this is about looking at cancer campaigns in their totality. The bid on public health is largely focused on new vaccines. For example, the flu vaccine is now to be given to more children. There are also some screening elements in the area of public health. That is led, largely, by the Joint Committee on Vaccination and Immunisation (JCVI) approach and what it agrees. Maybe Liz can talk about that a wee bit.

Mr Dunne: Does the public health bid include more than just promotion? Does it also include vaccinations?

Dr Liz Reaney (Department of Health, Social Services and Public Safety): It includes a number of sections. There are vaccination programmes, estimated at £5·3 million; a contribution of £1·7 million to the National Institute for Health Research; work on obesity, estimated at £0·7 million; screening services at £0·9 million; addiction services, £0·7 million; and then there is a selection of smaller initiatives, estimated at £1·2 million, which make up the total of £10·5 million.

You picked up an important point about prevention. Prevention is vital. It has been said that vaccines and clean water are the two most significant things in public health. By vaccinating people, we can prevent them from getting a disease in the first place. If we stop it at that point, we do not have to then deal with the infections, GP attendances, hospital admissions, critical care, mortality and so on. The bid includes three particular programmes. There is the children's flu programme. You are aware that, this year, flu vaccine is extended to all children, two-year-olds, three-year-olds and primary 6 children — healthy children — and that is the first time that that has been done. In the coming year, that programme will be rolled out further in its second phase, so that we will be offering vaccine to all children, preschool children from two years-of-age upwards, and all primary school children. Next year, we will be extending it into secondary schools. That is very much on the advice of JCVI.

Earlier, we mentioned unforeseen expenditure. The past year or 18 months has been a time of intense activity in new vaccination programmes. I do not recall such a time. People who have worked in the vaccine world cannot recall a time when there have been so many vaccination programmes introduced. It is all good news, because it prevents disease from occurring.

There are other programmes. We are all aware of the dangers of meningitis C. The schedule for that programme has changed slightly, and we are now introducing a catch-up programme for young adults aged 18 to 25, who are starting university for the first time in September 2014. This will protect them at a particularly vulnerable time. There is a high rate of carriage of meningitis, particularly in people of that age, with the coming together and close mixing of students in halls of residence, for instance. There is a very marked peak in the increase in risk, so we would be offering that vaccine to in the region of 12,000 students, and we would expect to see a reduction in risk for them.

Finally, I move to the shingles programme. You are aware of the severity of shingles, particularly in elderly people. The JCVI recommended that the programme be extended to people aged 70 to 79. It has to be done in a phased manner, due to certain limitations in the supply of the vaccine. Last year, we introduced it for people aged 70 and 79 and, in the coming year, we are extending it to those who are coming 70 this year and, then, those who are aged 78 and 79. We hope that we will be able to catch up in the cohorts in between over the next few years. This is something that we would very much support, because of the prevention and the benefits that can be gained from that.

Mr Dunne: Finally, you are looking for £10 million additional funding for clinical negligence. That falls within rationale "b", which, I think, means that it is inescapable but not fully committed. Are you not making progress in trying to reduce that problem by introducing new methods and trying to stop the recurrence of practices and processes that have been seen to be ineffective? They have been highlighted and identified as being risk areas. What are you doing to try to reduce those risks? What procedures are you putting in place to not only reduce them but eliminate them and try to cut the incidents? Public money is being wasted. Patients are suffering. As a result, everyone loses out.

Action should be taken to reduce that. You should not be looking for an additional £10 million; you should be living within the budget, at least.

Ms Thompson: You are absolutely right. The pressures we experience today in respect of clinical negligence will, in most cases, remain, or will relate to events that happened some time ago. There is a considerable time lag between the settlement of a case, which is what is impacting on the 2014-15 budget, and the actual incident that caused the issue in the first place. So, we need to ensure that lessons are learned earlier in the process. That involves part of the incident reporting system and how that works. It is about ensuring that lessons are learned. The Quality 2020 strategy is about ensuring that care is taken on the quality of services and on ensuring that there is an understanding, early on, about what caused a particular difficulty. The Quality 2020 strategy is about ensuring that that lesson is learned and shared across other trusts, as necessary. It is only through doing that that, in four, five, six years' time, you can minimise the clinical negligence settlements coming through.

It is a challenge everywhere. As the opportunities to treat people and the number of things you can do increases, so too does the element of risk. So, I do not think that it would be right to say that we can ever eliminate clinical negligence. That will not happen. However, equally, we need to ensure that the lessons are being learned. There certainly has been a lot of focus, in recent times, on trying to ensure that that happens, but the effect will not be seen until further years down the line, because of the time lag involved in dealing with the cases.

We are also looking at whether there are other ways of dealing with clinical negligence settlements, rather than getting to that point in the first place. It could involve looking at how complaints are managed, whether mediation would help or whether alternative dispute resolution procedures would help. How to avoid getting to the space of clinical negligence in the first place, as well as learning the lessons from what caused it, are part of the agenda moving forward, because we need to try to manage the spend in that area so that we can put more resources into front line care.

Mr Brady: I just have a comment. The RCN gave us a presentation a few weeks ago on TYC, and its comment was that it is a vision without action. What you have said today has reinforced that. It seems to me that the cart has been put firmly in front of the horse; the cart being the strategy and the horse being the money. At the moment, the horse is struggling greatly to catch up with the cart. The cart seems to be rolling downhill at a very fast pace, and the horse simply is not keeping up. It seems strange that you have a strategy that has not been properly worked out in money terms.

Gordon made the point about winter pressures. That is recurring. I have heard that since 2007. I know that hindsight is great, but foresight is even better. It seems to me that there should be a bit more foresight applied, and it seems that that is simply not happening. Transforming Your Care seems to be running into more obstacles than anything else that has been put forward in the past number of years. If you have not got the money, how can you possibly implement it? If that was not planned for, you are just playing catch-up all the time.

Ms Daly: If I could pick up on that point; £70 million of transition costs are required, and that was clear; but that is not the whole of Transforming Your Care. There is a lot of action being taken forward on various strands of it, and it is right across all trusts. A key element of Transforming Your Care was the establishment of the 17 integrated care partnerships, which are up and running and are beginning to produce work with respect to identifying better care pathways and addressing the needs of the frail and elderly. By its nature, it is going to take some time to see the outcome of that and evaluate the effectiveness. So, it was never a case that it was going to deliver extremely quickly.

The more progress that is made as early as possible the better, because Transforming Your Care made the case very clearly that all of the things we see impacting across the budget, including the demographic change, the long-term conditions, the ageing population, mean that we need to make the changes in delivering health and care services envisaged in Transforming Your Care. So, although there are elements that, if we do not get funding, will impact on that, huge elements of the programme are still moving forward across all the issues, and we are up to 99 proposals. It is important that we do not convey that this is the entirety of TYC but that a number of strands of work are continuing. Equally, funding is required to do TYC, as envisaged in the report.

Mr Brady: With respect, in terms of the 17 centres, the one in my constituency is not moving forward that quickly. In respect of the privatisation of those centres, it would be very difficult to dissuade people from the notion that not only is Transforming Your Care supposedly a shift left but it is very

much a shift towards privatisation. I think that you are going to have a very difficult job persuading people otherwise, to be perfectly honest. I will leave it at that.

The Chairperson: OK. Thank you. The very clear message coming from this is the need for clarification, particularly on the Transforming Your Care transitional funding. It does not provide a lot of logic to me that issues such as the bid for public health — all desirable projects around vaccinations etc, and early intervention and prevention — have huge merit. It does not tally up to me that a bid for that type of work, desirable as it is, would be of higher priority than the transitional funding that is required for the entire strategic framework for the new delivery of health.

I suggest that we seek — you heard it clearly from members today — an explanation of why the bid for transitional funding would be categorised as "c" and an explanation or assurance going forward that, as a result of being classified as a "c", that it does not put the entire framework at risk. We need to get a sense in writing from you of the fact that, as we move on, we only have £28 million in the system out of a £70 million bid and where the risk assessment is in the system. Equally, we need to seek assurance around the children's hospital.

Ms Thompson: I am happy to come back to the Committee —

The Chairperson: I am listening carefully to what you say, but, ultimately, £10·4 million is being returned to the system. Are there implications for timescales, or is there any potential risk to the project? We certainly know that you are on a timeline. I think that the bid has to be with DFP by 5 June.

Ms Thompson: Yes.

The Chairperson: So, we would appreciate a response ASAP on those issues.

Ms Thompson: OK.

The Chairperson: Thank you for your time today.