Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Departmental Approach to Budget 2015-16: Mr Jim Wells MLA, Minister of Health, Social Services and Public Safety

22 October 2014

NORTHERN IRELAND ASSEMBLY

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

Witnesses:

Mr Wells	Minister of Health, Social Services and Public Safety
Mr Richard Pengelly	Department of Health, Social Services and Public Safety
Ms Julie Thompson	Department of Health, Social Services and Public Safety

The Chairperson (Ms Maeve McLaughlin): You are very welcome. Minister, there is a bit of role reversal here. Let me say, on behalf of the Committee, that we look forward to continuing engagement with you on a wide range of issues. I advise members that the Minister is here to give evidence on the terms of reference for the Committee's review of the departmental approach to the Budget. This is a key area of work for the Committee. From the Department, we have Mr Richard Pengelly, the permanent secretary, and Ms Julie Thompson, who is no stranger to the Committee. Let me advise you, Minister, that the purpose of the review is for the Committee to assess the Department's approach to the Budget for 2015-16. As you are well aware, this is part of our statutory function of considering and providing advice on departmental budgets and annual plans in the context of the overall Budget allocation. We understand that the draft Budget for 2015-16 has not yet been published, but we expect that the Department is planning how to spend its allocation for that period on the basis, I suggest, of a range of scenarios. Today, we want to hear what those scenarios are, look at what is being planned for and hear how you intend to prioritise spending areas. We are all mindful of the extremely challenging financial situation for the Assembly. At this point, I ask the Minister to make his presentation.

Mr Wells (The Minister of Health, Social Services and Public Safety): Thank you, Madam Chair. As you know, I spent five very happy years on the Committee, and I know most of the people around the table. Let me introduce you formally to Richard. He replaced Andrew McCormick as the permanent secretary, and this is his first appearance before the Committee. Julie, as you know, has a

season ticket to this Committee and has been here many times. She is extremely experienced and more than capable of dealing with all the difficult questions. I will make an introductory statement and then, I think, as is normal, you will throw the meeting open to members' questions.

I thank the Committee for the opportunity to discuss the Department's approach to the Budget for 2015-16. Obviously, before we discuss 2015-16, members will, no doubt, be concerned about the financial position for 2014-15. As you will recall, I made a statement on that issue on Tuesday week ago in the Assembly. As you are also aware, my Department recently received an initial allocation of £60 million in the October monitoring round. That was against a bid of £130 million. That is on top of the conditional allocation of £20 million in the June monitoring round. Obviously, the £20 million is extremely welcome, but there are still consequences for health and social care provision for 2014-15 because, in the absence of the full requirement that we asked for, there is simply not enough money to maintain current levels of provision. So, we are still £70 million short of the identified need, and the trusts have prepared a wide range of contingency plans to address that deficit. I intend to make a final decision in relation to 2014-15 before the end of this month, and my officials will attend the Committee on 5 November to discuss it. That is Guy Fawkes Night, so I hope that there is nothing symbolic about that date.

Measures will be deployed for living within the budget for 2014-15. In other words, to live within that budget, we are going to have to implement measures such as delayed service developments or the additional funding that the Department may require for 2014-15 monitoring rounds. Those, of course, are non-recurrent measures; in other words, that additional money is only available for 2014-15 and cannot be used to secure services for future years. I think it is very important that we realise that. That means that the full-year effect of the £160 million of unfunded pressures for 2014-15 will roll forward into 2015-16 and will need to be addressed in that year. We are still in the early stage of the process for the 2015-16 Budget, and you alluded to that, Madam Chair. We have not reached agreement on the draft allocations for Departments. However, in the briefing paper to the Executive, the Department of Finance and Personnel advised of a proposal that would provide an additional £100 million to DHSSPS for 2015-16. This planning scenario has been included in the briefing paper to the Committee.

We are also at an early stage in the internal planning process for 2015-16, and the extent of the new pressures is being assessed and refined. On top of the unfunded pressures that are being carried forward from 2014-15, the new pressures arising from 2015-16 are substantial, and they are currently estimated to be £330 million. As I am sure you will agree, that is a large figure. The largest inescapable pressure within this is in relation to the additional pension costs, which are estimated to be between £80 million and £90 million. This is money that DFP is requiring of us and all Departments to make up the shortfall in pensions. That will not cure one ingrown toenail. That is money that will simply come out of our budget and go into the pension pot to fund future costs in that field. So, that is not really extra money as far as we are concerned. There are also significant pressures in relation to demographic changes, National Institute for Health and Care Excellence (NICE) drugs, elective care, and mental health and learning disability resettlements. These pressures relate to my strategic priorities for the Department, and work is ongoing to clarify the requirements, informed by the position from 2014-15.

I assure the Committee that all available savings will be pursued in 2015-16, but, based on experience, if we could achieve savings of 3%, this would mean that £140 million would be available to offset against these pressures. Indeed, given the serious of the financial outlook, the pursuit of savings will necessarily be wide-ranging across all areas of service, including that of potential income generation. In overall terms, after assuming 3% savings and the additional Executive income of £100 million, this would leave my Department facing a funding gap of nearly £300 million that still has to be resolved for 2015-16.

The development of my strategic priorities and the commissioning plan directive for 2015-16 is also at the early stage as we seek to understand the potential resource implications. Final decisions will be informed once the Budget position for 2015-16 is clarified. I will, of course, be providing an opportunity to the Committee to comment on the commissioning plan directive before it is finalised.

While the Executive have not reached an agreement on the 2015-16 Budget position, it is clear that 2015-16 will be an exceptionally challenging year for the Department, regardless of whether my Department will be offered any protection form public expenditure reductions. Indeed, even under the planning scenario above, with an additional £100 million in 2015-16, there are still fundamental issues to be resolved. In the light of this, the Executive must decide on the relative priorities for public expenditure in Northern Ireland for the years ahead and whether they can afford to pay over £100

million, which will be wasted in welfare reform penalties. I suggest that the health and well-being of the people of Northern Ireland must surely be the Executive's top priority, and the Budget process for 2015-16 provides an opportunity to ensure that budgets are aligned in accordance with this.

Thank you, once again, for this opportunity, and we are quite happy to take any questions that you may have.

The Chairperson (Ms Maeve McLaughlin): Thank you, Minister. I am very mindful that what we are discussing today is going forward as 2015-16, and I am reluctant to open up any discussion around the current situation. However, you referred specifically to strategic priorities. What are they? What are your top three strategic priorities?

Mr Wells: Obviously, the provision of high-quality front line care has to be a main priority for any Health Minister, and that is extremely difficult. It is worth saying that, in order to achieve that in our first three years under Edwin's control, we were able to achieve efficiency savings of £490 million, which we then diverted to more important top priority issues. This year, despite the difficulty that we are in, we are making efficiency savings of £170 million, which, again, will be diverted away from less important priorities to the top front line care. Next year, we are basing it on an assumption of 3%, which is £140 million worth of efficiency savings. That has to be the quality of the care that the person in the clinic, the GP surgery or the hospital gets.

Secondly, of course, there is Transforming Your Care, which has been an incredibly important aspect of the work of the Department. Most of us in the room discussed and pored over John Compton's proposals. His basic tenet was simply that we cannot continue to fund a health-care system in 2020 if we go on the way we are going. There had to be radical change, which was because far too many people in Northern Ireland were too high up the ladder of health-care provision commensurate with their needs. Therefore, that issue has to be sorted out.

It might not be a priority at the moment, but what is also very important is looking at opportunities for increased revenue generation within the Department. It is clear that, until 2020, we will have a flatline budget for all of Northern Ireland plc, but the Health Department, if it is fortunate, will get a basic resource similar to the previous year, plus maybe 1% or 2%.

The difficulty, as everyone on the Committee will accept, is that demand is rising at between 5% and 6%. I was in Limavady with George Robinson two weeks ago and was told by the Ambulance Service that the number of calls is rising by 5%. There has been a 42% rise in demand for cancer services in a 10-year period. The fundamental problem that we are going to have to address as a priority is how to ensure good levels of front-line care, given that demand is rising inexorably.

The Chairperson (Ms Maeve McLaughlin): Thank you. I appreciate that you outlined three top priorities. I want to tease those out a bit more. You talked about high-quality care. Nobody around this table would take issue with that in terms of front-line care. Is that almost a shift from the focus that there was on the early intervention and prevention model?

Mr Wells: Given the financial situation, the next five-month period will be more of a firefighting process to make the books balance and continue a level of care. Strategic planning will be more for the future, but, at the moment, my priority is to ensure that at the end of March 2015 we have maintained front-line services while keeping within budget. That is an absolute priority. Longer-term early intervention is essential, but that is my priority.

The whole Public Health Agency (PHA) budget has to be looked at because we have to stop people making lifestyle choices that inevitably have an impact on their health. I was in Cuba with the Committee Clerk and the former Chair, and we saw that country's amazing emphasis on health. They do not have a Health Minister; they have a Public Health Minister, and everything is geared to ensuring that that community does not get itself into a situation where it requires expensive, long-term care.

There are many issues to be learned, but my priority this year is to make certain that we find ways to reach a budget that does not have an impact on the needy, vulnerable and chronically ill. That is an extremely challenging target.

The Chairperson (Ms Maeve McLaughlin): Can I take it from that, Minister, that you are saying that in the here and now the focus is on that high-quality, front-line care, but that, in your 2015-16 budget, it would be on the preventative early intervention-type model?

Mr Wells: Unfortunately, as I said, the budget for 2015-16 is even more challenging than 2014-15. The immediate problem I face is that, even with 3% efficiency savings, I have to somehow find £290 million to £300 million, particularly if DFP continues to ask for £80 million to £90 million for pension provision. That is an enormous hole in our budget, and it is probably going to be unavoidable.

I know that issue is being looked at, but, in the first week of April, you start £100 million down. We were looking for £160 to address pressures, and we got £80 million, but remember that that was a one-off payment under the June and October monitoring rounds. That funding is not carried into next year. We then start afresh with the same pressures and have to find additional money to pay for those. So, you carry forward the pressures of £160 million. You carry forward a deficit in your pension provision of between £80 million and £90 million. Indeed, I recently saw a figure of £97 million. If things really go astray, that is what we would have to pay. You then have growth on top of that.

That is the difficulty that we, as a Department, face in trying to balance the books. It is very gloomy, but you never know what can happen; extra money could be found. What I can tell you is that there is very little in the way of money coming through in the monitoring rounds for the rest of this year. It is a tiny amount.

The Chairperson (Ms Maeve McLaughlin): We are mindful of the difficult situation. We want it all in terms of Health; we want the biggest fix that we can get. However, if there is a situation where the identified gap is not met, what are the strategic priorities? How do the Department and you say, "This, initially, is where money has to be spent, and this is where money will stop being spent."?

Mr Wells: We are in that process now. As you know, Madam Chair, the trusts have indicated that they are £133·3 million over their budgets for this year. Obviously, some of the £80 million will help to bridge that gap, but each of the trusts have been asked by my private office to come up with a programme to bring the books into balance. We will not have the opportunity to carry forward debt into next year; we are going to have to keep within budget. That is extremely challenging. Some of the trusts are in extremely painful situations, but we have no other option. People think that the £60 million is extra money. It is not; it is to meet commitments that we have already made where the money has been spent on essential care. The £20 million is conditional on us balancing the books. I am confident that we can convince DFP of that. We do not see any other substantial amount of money coming into the coffers of DHSSPS between now and the end of March.

Going back to the monitoring rounds, we see no big-ticket project on either the revenue or capital side that is going to yield what the A5 did in capital moneys last year in terms of a windfall. We know that those projects are just not out there. Most of them have started, and we are contractually obliged to them. I hate to paint an entirely negative picture, but budgets will be the most difficult issue with which we will be challenged this year and next, unless something dramatic happens, such as a change in Government at Westminster, and more money is paid in.

There are parties around the table that have some of the solution in their hands. We have paid £87 million in welfare reform penalties this year. It will be £119 million next year, and heaven knows what it is going to be in year 3. Remember that, normally, 40% of that money would be the Health Department's; we normally consume about 40% of the Budget. If I had the £32 million as my proportion of the £87 million that is being paid this year, that would go a long way to meeting issues such as elective care. If I had my 40% of the £119 million, which is over £40 million, next year, that would be exceptionally handy in terms of funding the gap. Can we, as a society, continue to pay those penalties without impacting on health-care provision? It is very difficult. Of course, that money is not buying any extra services for my Department; it is a fine.

The Chairperson (Ms Maeve McLaughlin): I do not want to open up a debate with you around welfare cuts.

Mr Wells: No, Mickey will do that.

The Chairperson (Ms Maeve McLaughlin): Possibly. We can do that at a later stage, but I do not think that that is what people listening to this want to hear at this stage. We are very mindful of moving forward on this. I have outlined that it is not about the current situation, as difficult as it is. If I

was to take what you have indicated to me, I am right to say that your three top priorities are high-quality, front-line care, Transforming Your Care and increased revenue generation.

Mr Wells: Budgetary control. Budgets encompass all of that.

The Chairperson (Ms Maeve McLaughlin): Is that for 2015-16?

Mr Wells: We, as an Executive or as Departments, have not yet come to a conclusion on 2015-16. I do not yet know what I am getting, but we are giving an indication: it is this year's base plus £100 million.

The Chairperson (Ms Maeve McLaughlin): I accept that, Minister, but surely the Department and you know, depending on what you get, where money should be targeted and prioritised.

Mr Wells: I will use this card once and once only: I am in post only 29 days. Therefore, you would hardly expect me to be the font of all knowledge as yet on the issue. When we work through 2014-15 and see where we stand, we will have a much clearer idea of where we are going in 2015-16. We will also be given notice by DFP of exactly what we have, although I suspect that it will probably not be much more or much less than the £100 million plus base. We are not yet in a position to do that but, by 5 November, you will have a clear indication of where we are going in 2014-15, and that will give us a steer as to where we are going in 2015-16. It is, by far, the most time-consuming issue that I am dealing with at the moment. It is a very difficult one, and, as you know, the previous Minister had great problems with this, even with his three years' experience. It would be wrong of me to start to give chapter and verse, having only been in the post for only 29 days, although I have to say that it feels like 29 months.

The Chairperson (Ms Maeve McLaughlin): OK. I reiterate the point. Departments and Ministers will have priorities. We are asking what those priorities are. This is on a similar vein, Julie. When you were in front of the Committee a number of weeks ago, you were asked specifically about the monitoring round. At that stage, you indicated that the bids submitted had come from a list of "uncommitted funds". You said:

> *"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'."*

It is back to this question again: given that there is free rein in how you spend your allocation for 2015-16, what things would you stop funding?

Ms Julie Thompson (Department of Health, Social Services and Public Safety): For the October monitoring round, we looked at the position in the middle of the year, at what was remaining to be spent in the latter part of the year. As we look into 2015-16, the first place to start is with the sum that will be spent, or which it is proposed will be spent, around just effectively keeping existing services operating. So that is: pay, non-pay items of expenditure, inflation, demographic growth, family health services (FHS) growth — all those things and the pensions that the Minister has already talked about. That sum is effectively £200 million, and that has to be managed. There is just no way of getting around that level of base growth within the budget. On top of that, you are into areas such as, for example, elective care and what resources are needed to manage the demand in that. Yes, absolutely, that includes public health and public health initiatives. There would be plans around, for example, how to expand vaccination and screening programmes and things of that nature. We would look at children's services, NICE drugs, special services, mental health and learning disability — those all create ongoing demands within the system. And equally then, there is transitional funding to sustain and keep TYC operating.

That is a long list, and it is in the briefing paper. The list is not dissimilar to what the Committee is familiar with our bids for money in the past. The issue around looking at a scenario is that we are not even at a scenario where the basics can be funded at this point, never mind, therefore, identifying what is top priority out of those service developments.

What would end up happening is that we would refine that analysis with the trusts. We would look to see what efficiencies could be put against that, look at the executive income and then put a lot of effort into finding out what is the minimum level that could be incurred within each of those areas. That is the work that has to happen when we get a more realistic scenario. We are just not at a point within

the budget planning processes where that has been done. So, absolutely, we know the areas, the types of expenditure and the opportunities, if you like, around those; but we still have to do a piece of work, when we get more clarity on the budget, about what would then come to the top of the pile. As we know from monitoring bids, it is not as simple as drawing a line where the money effectively ends. It ends up being an element of each of those things that I have talked about potentially being funded as we look forward. However, we have not even got to a point where the basics are sorted yet, never mind the service development side of the piece.

The Chairperson (Ms Maeve McLaughlin): What I asked was what you would stop funding?

Ms Thompson: You are then looking at what you can do in efficiencies. Again, we have a piece of work ongoing with the trusts around all parts of the service, whether it be the acute sector, social care, staff productivity, and whether, as the Minister has already mentioned, there is potential for income generation. You are looking right across the piece. The ultimate priority is safe, high-quality services and, therefore, what does that mean that you cannot afford to provide? We are not at a point where we can name particular services at this stage, because we need to understand more about what the budget looks like at its highest level. Our commitment to the Committee is that we are looking right across the board for all the savings that can possibly be achieved in order to put against the deficit.

The Chairperson (Ms Maeve McLaughlin): I think that it is a wee bit more than just efficiencies or savings, but what stage is that work at?

Ms Thompson: The work is at the stage where we have a process ongoing. We have a high-level list of areas that are being looked at between ourselves and the Health and Social Care Board (HSCB) and the trusts. Various options around that will be presented to the Minister, and we will move that forward. Whilst there is an assumption of 3% efficiency within the paper, we are committed to make that number higher if we can. We will try to maximise what we can. We need further clarity from the DFP process about what the ultimate budget will look like as we move ahead, and that is just not there at this point.

Mr Wells: When I look at that list, my basic question will be, "Does this have an impact on front line care?". If it has no impact, that makes the decision much easier, but I suspect that as we go down the list it will start to have an impact.

Just to clarify the present situation: had we a blank sheet of paper in advance of the financial year, we would not be implementing the cutbacks that we are implementing at the moment. We are in a situation where 63% of our budget is to pay national insurance and pensions, which we cannot do anything about because were we to make people redundant it would be three years before you get any payback. Another £500 million of the budget is in contractual obligations that we cannot get out of. Therefore, I am left with a very small section of the budget where we can make efficiencies and reduce expenditure. The obvious thing is elective care. We are under no contractual obligation to provide elective care outside of the trusts. That is something that can be turned off or on as required to fit the budgetary situation.

So, are we making logical decisions? We are not. We are making practical decisions on which we can deliver. It is an invidious position to be in. Next year, of course, we will have a different scenario, but I make it absolutely clear that, as things stand, next year is going to be much worse.

The Chairperson (Ms Maeve McLaughlin): OK. In a similar vein, the Finance Minister recently — it may have been in Question Time and I am paraphrasing— referred to the difficult conversations about the strategic direction of Health. Do you have a view on that?

Mr Wells: The Minister of Finance and Personnel has an invidious role. His job is to keep all Departments within their budgets. It is very difficult, but that is his responsibility. Therefore, there will always be difficult conversations between officials, the Minister of each Department and Mr Hamilton's office. Clearly, Health being largest spender — we spend about 40% of the revenue — we obviously have more conversations with Mr Hamilton than perhaps anybody else. If our budget goes astray there are profound implications for the Executive's entire spending. However, that difficult conversation is no more than one would expect, given the relationship between the Departments. Indeed, if Mr Hamilton were not having those difficult conversations he would probably be negating his role.

The Chairperson (Ms Maeve McLaughlin): Yes. I am just pulling up what he said, which amounts to a wee bit more than Mr Hamilton having difficult conversations. He said:

> *"We also need to have a strategic conversation as an Executive, an Assembly and a society ... about what our priorities in health are, what must be absolutely protected and what can be done, perhaps, in slightly different ways." [Official Report, Vol 98, No 3, p54, col1].*

Mr Wells: Yes, and I agree with him on that, but remember that spending in Northern Ireland compares closely to that in England, Scotland and Wales. It is not as if we are widely out of line with the rest of the UK and other developed countries. At the moment, I do know if we will have the luxury in the next 18 months to have much strategic thinking on this. Unless something changes radically, we are going to spend most of our time trying to balance the books. That is going to be very difficult. I am under no illusion: we have problems. I paid tribute to Edwin Poots, and you may recall that, in the first three years he was Minister, Mrs Thompson came forward and told us that we had balanced the books and budgetary issues did not feature strongly at this Committee. I say that as an insider. For the last five years, I have regularly met all the chief executives of the trusts. On every occasion for the first three years, they said that this was challenging but they could do it. This year, they are telling me that what they are being asked to deliver it is terribly difficult.

The Chairperson (Ms Maeve McLaughlin): OK. Finally from me, you talked about high-quality front line care. Part of that is around our GP service. There was reference to 24/7 services. I suppose that the shift left, which, in my view, is the right principled approach to take on policy, has put increased pressure on GPs. I noted that GP activity had increased by 7% over the last year, and there is huge dissatisfaction out there. That was highlighted in a recent Patient and Client Council report, where 26% of people surveyed said that they were dissatisfied with access to their GP. So, how do you address that?

Mr Wells: I am meeting Tom Black, who is the chair of the Northern Ireland committee of the BMA, tomorrow to discuss a wide range of issues, including this. We need the cooperation and support of GPs to deliver Transforming Your Care. His stats bear out my contention that, on average, demand is rising by 6% per annum across the entire field of health. We are going to work closely with the BMA to ensure that we can get it on board with the necessary changes, because GPs have a crucial role. The basic tenet of Transforming Your Care is that people are too high up the ladder of healthcare provision. The bottom of the ladder — I do not use that in a derogatory sense — is the GP level, where you must try to ensure that as much care as possible is delivered, because, each time that you go up that ladder, the cost more or less doubles. We need to avoid that happening.
So, I want to have a good engagement with the BMA. Of course, I have met it many times over the last five years, but I had not really any power to do much apart from listen to what its representatives were telling me. Now, we want to have a very good close working relationship. I will add that I know that the BMA will be asking that the overall percentage of the budget that is spent on GP care goes back up to the historical level of being about 9% of the budget. The cost of that would be well over £150 million, and that would be extremely difficult to deliver at the moment in the financial situation that we are in. Will we cooperate? Yes, we will. Will we do all that we can to make certain that they play their part in Transforming Your Care? Of course.

The Chairperson (Ms Maeve McLaughlin): Will you accept that there is potentially a workforce crisis in general practice because of the shift left?

Mr Wells: General practice is under huge pressure, not only because of that but because it is not an attractive option at the moment for young medical graduates. They are tending to steer towards the hospital base, and the average age of GPs is getting older and older. Some of them are even as old as I am, and that is something to worry about. We doing a review of workforce planning, as you know, and one of the things that we are doing as part of that is to see whether we can encourage young medical graduates to see GP surgeries as an attractive option rather than going down the route of going into an A&E hospital and perhaps going down the consultancy road. So, there are many, many issues that we will have to address with the cooperation of Tom and his team in the BMA.

The Chairperson (Ms Maeve McLaughlin): Richard, we will not let you off the hook at your first meeting. You are welcome, and we hope to see more of you. Specifically around the issue of GP numbers and maybe training for undergraduates, are there proposals or is there thinking around that?

Mr Richard Pengelly (Department of Health, Social Services and Public Safety): I have met Tom a couple of times, and he certainly has some thoughts on it. We want to continue the dialogue, and, indeed, the Minister is very keen to meet Tom. Unquestionably, there are issues with GPs, but I think that it goes back to the core issue that the Minister alluded to. If we take any area of the health service in isolation, there is a very powerful case for more funding and a different methodology for it. The challenge that the Minister faces is of trying to bring all those individual strands together within a very difficult funding envelope and making those difficult choices. If we want to invest more money in primary care, that needs to be sourced somewhere else within a fixed overall envelope. Those are the choices and issues that we will be looking at as we go forward with our planning for 2015-16.

The Chairperson (Ms Maeve McLaughlin): Those conversations are taking place. I ask that the Committee be kept informed of those discussions as they continue. I close by saying that the shift left, the focus from acute to community and primary, brings, and has brought, its own challenges to front line primary care. That needs to be enhanced and supported, in my view.

Mr Wells: Madam Chair, you said something that worries me about having GPs 24/7. We are not asking for that but for some flexibility, for instance surgeries being open one evening a week and perhaps being open on a Saturday morning to provide flexibility for people who are working from 9 to 5 and who cannot get to their GP normally. That is the sort of level, but we are certainly not envisaging a radical change in opening hours every evening and every weekend.

The Chairperson (Ms Maeve McLaughlin): I do not want to open this up. It is an important issue. It goes back to the whole issue about things like GP out-of-hours services and the support that is there to deliver that. There are some areas in the Western Trust that do not even have that service.

Mr McKinney: Thank you for your presentation. Given the high priority that you are attaching to TYC, what is the projected spend, the budget allocation, for next year? That is, what are you preparing to spend on TYC next year?

Mr Wells: Julie is the expert on the numbers on this issue. I can tell you that it probably will not be enough. We could certainly do with more in that particular field. Julie, can you lead on that?

Ms Thompson: Respecting that it is an early stage in our looking at 2015-16 and partly because we are also working through the finalisation of 2014-15, as we look at Transforming Your Care into next year, we would like to be able to look at funding more in integrated care partnerships (ICPs) and, effectively, looking at outpatient reform and care pathways. When we look at that, spend could be, I guess, somewhere in the region of the order of £15 million, £16 million or £17 million in 2015-16, although that is yet to be worked at in full detail. That is the point that we are at currently. Obviously, we need to work that up in more detail and clarify what that would sit alongside affecting all of the other priorities that I was talking about. When we know what the budget really looks like, we will figure out how much of that is affordable, what we can do about it and how we can effectively look at the priorities within that. That is the order of what it could potentially need next year.

Mr McKinney: Is that in any way consistent with it being a top priority, given that you bid for £29 million in June monitoring and dropped that to £2 million in October. So, you are already shy. Is £15 million anything consistent with it being a top priority?

Ms Thompson: We bid for £21 million last June, and, yes, you are right that we bid £2 million-odd in October monitoring. That was because £12 million effectively had been spent, so as we look at what we expect to potentially be a spend rate — this is yet to be fully bottomed out in 2013-14 — it feels somewhere in the order of £13 million or £14 million in 2014-15, based on where we are looking at currently. As we look into 2015-16, it feels like a similar sort of figure, and the question is whether that is affordable in the round, in line with the Minister's priorities, and what it will look like. Ultimately, it will be a very challenging envelope when, effectively, we do not have enough to fund the basics of life.

Mr McKinney: Since we are talking about feeling our way around the figures, it does not like feel like a substantial figure to me, given that the Minister prioritises it as number 2.

Ms Thompson: Again, it is about recognising where we are. We have £200 million rolling forward from —

Mr McKinney: Sorry, Julie, it is a priority or it is not a priority. At the beginning, we asked what the strategic priorities are. One might assume, with an element of sarcasm, that that might attach to it a significant figure, given that the Transforming Your Care plan is about putting money into the community in an attempt to save overall. So, why is the figure, even that which is projected in the early stages of these discussions, not consistent with that priority?

Ms Thompson: On the prioritisation, I am saying that we have a significant element of funding that needs to be addressed first, before we get to any additional funding for any service developments, no matter what priority, because that is about maintaining the services that we currently have.

Mr McKinney: So, when is a priority not a priority?

Mr Wells: When you have not got the money to pay for it.

Mr McKinney: So, it is not a priority.

Mr Wells: It is a priority, but, Fearghal, what I am trying to say is that we are in a terribly difficult financial situation. John Compton did not envisage the desperate budgetary situation that we now find ourselves in, and that is making it very difficult to deliver what would be the optimum funding for TYC.

Mr McKinney: I understand, Minister, but the conversation that we are having is about next year's budget and the priorities in it. At the outset, we asked what the priorities were. I am just making the assumption that TYC is also about cost saving. It is an invest-to-save project, if you like. If it is a priority, will it get priority status in the budget, or will it not?

Ms Thompson: Ultimately, all I am explaining, as a scene set to that, is that, effectively, we are running from 2014-15 at £200 million plus another £200 million in 2015-16 to deal with existing services. If we get additional money from the Executive and also savings against that, part of that will be worked through, but we still have a significant shortfall on that. When you then look at the priorities of where new money would go and how that will pan out, we looked to see what TYC needs in 2015-16. An early assessment shows that it is similar to the spend levels of 2014-15. We then need to know what the Budget in its totality will bring and, therefore, how much is available to meet those priorities.

It is a bit like what Richard said: looking at one aspect of the budget in isolation is challenging and difficult because we have TYC, primary and elective care, mental health and NICE drugs. The Minister also spoke about the quality of care, and a lot of those would be encompassed in that because they are all about quality healthcare provision.

Around £15 million feels like the order of what it would need in 2015-16. We definitely need a more realistic budget scenario to see how much of that could be financed. That is the stage we are at. When he gets more clarity on the budget, the Minister will need to reflect on what is affordable within the priorities.

Mr McKinney: You probably have answered this question, but I will put it another way. The experience of October monitoring shows that monitoring cannot be relied on any more. In submissions in the Chamber and elsewhere, it was reflected by the Department that Transforming Your Care was, in fact, going to be funded out of monitoring. It was not in the original budget. You are now not going to get it in the budget for next year, so where does that leave Transforming Your Care?

Ms Thompson: It absolutely is in the budget scenario in the figure work that was presented to the Committee but we have a £290 million gap at the bottom of that analysis. It is absolutely there in the budget. When we understand the budget more clearly from the Executive, we then need to find out what is affordable. That is where we are at the moment. That is just the matter of fact of where we are.

Mr Wells: Fearghal, you are a prolific writer. I seem to be sending letters to you every day. In many of those letters, you quite rightly demand better services for the people of south Belfast. They are all about hips, orthopaedic care and cancer care. That is your role, but delivering a high level of patient care is such an overwhelmingly dominant priority in health that it will take us an awful lot of time and effort to deliver just that. Other priorities will be much more difficult to deliver. I do not mind MLAs

pushing me on that, but everybody in this room has already written to me demanding more to be spent on other services, not TYC.

Mr McKinney: I understand. That is my job, and your job is a different one. Your job is to convince us and the public that the plan, which was at the centre of moving the health service forward in a defined time span, is actually on course. I am only trying to interrogate whether it is on course. For example, given the threat to the Budget monitoring round, would it not be likely that you would put in all your money against TYC now and put it into the baseline for 2015-16?

Mr Wells: In an ideal world, yes, but the problem is that in order to do that, I would have to take an equivalent amount of money out of cancer services, pharmacy, and domiciliary and elective care. If I do that, that will impose a lot of pain on people.

You have to recall that, for the first three years of the CSR, it was a hard fight for the Department, but, at the end of the day, we did not have this conversation. They did balance the budgets. Therefore, we had the luxury of being able to allocate a more reasonable level of funding to TYC and, hopefully, pick up a reasonable return in monitoring rounds. We have now moved to a situation where it is so difficult that we are firefighting to keep the basic services running. That is our difficulty.

Mr McKinney: I understand that. What I am really trying to do is, within all that, put some context on where Transforming Your Care is. You say that it is in the budget scenario, but it is way down the list. Would you agree that its priority is low now?

Ms Thompson: No. What I would say is that we have to find the money to maintain existing services. After that, it is on the list and, as the Minister made clear, he would want to provide additional funding to it. It is still a high priority for the Department, but that has to be within the resources that we get.

Mr McKinney: Yes, but I go back to what the Finance Minister is saying. He is facing pressures, as are we all. In relation to the 6% figure, he said that the measures and reform plans introduced by Edwin Poots for Transforming Your Care need to be implemented, but you are not going to do that.

Mr Wells: It is worth saying that the entire Assembly agreed that those reforms were required. The entire Assembly, with one or two notable exceptions, voted for Transforming Your Care on three separate occasions, but we did so in a totally different financial situation.

Mr McKinney: This is reaching a conclusion. If you are saying that, where is Transforming Your Care now? Can it exist in any meaningful way?

Mr Wells: Transforming Your Care will continue, but it is not continuing with the speed at which we wanted it to proceed.

Mr McKinney: Will you reflect that in the staffing at the board, given the 25% increase in staff there?

Mr Wells: You cannot lay that at the door of Transforming Your Care entirely. Many functions have been transferred from other branches of the Department into the board level. I have had quite a good look at this, and it is not as it seems. To be honest with you, I am looking at that. One of the other proposals is to have a 2·5% cut in administration costs in all branches of the Department as part of our savings plan. The board will have to take its burden as well. The actual number of people working on the board is now lower than it was in 2008. There has been a decline in numbers, despite the fact that we have transferred more staff into that particular office.

Mr McKinney: I am conscious of taking a bit of time, but may I put just one more question to the Minister?

Mr McGimpsey: What board?

Mr Wells: The Health and Social Care Board.

Mr McGimpsey: It did not exist in 2008.

Mr Wells: Yes, but the equivalent organisations, such as the Central Services Agency (CSA), etc. You add them together —

Mr McGimpsey: The board plan was for 150 staff. I allowed it to go to 250 after I set it up. I understand that it is sitting at 520 today. The maximum should have been 250, if my memory serves me.

The Chairperson (Ms Maeve McLaughlin): OK. Carry on, Fearghal.

Mr McKinney: Finally, Minister, you have probably been reading in the national press of how the Conservative Government are at least briefing it about how they view the NHS reforms. They are categorising it in private briefings appearing in 'The Times' as their biggest mistake. Given the fact that we followed some of those plans in many ways, was it our biggest mistake too?

Mr Wells: First, may I say to Mr McGimpsey that, in 2008-09, the equivalent organisations had 621 staff? Today, the Health and Social Care Board has 549 staff.

Mr McGimpsey: The idea was to shrink the numbers, Jim —

Mr Wells: That is a significant drop.

Mr McGimpsey: Not simply move them over.

The Chairperson (Ms Maeve McLaughlin): Let us get back to Fearghal's question.

Mr Wells: Sorry, Fearghal, I was so taken aback by Mr McGimpsey's comments.

Mr McGimpsey: You should not have been.

Mr McKinney: Nationally, the Conservative Government are reflecting on the approach that they took to the NHS, and they are saying that it was their biggest mistake — at least that is how it is appearing in comments in 'The Times'. Given that we followed some of that direction, was this our biggest mistake too?

Mr Wells: Fearghal, while all of this is going on, we have a lot to be proud of in the outcomes in health and social care provision in Northern Ireland, be that in cancer, heart surgery or the use of modern drugs. Last year, there were 6,800 complaints lodged against the health service. That is a tiny fraction of 1% of the procedures that we carried out. The vast majority of people who go through the health care system feel that they have been treated well and are very happy with the level of provision. If it was not for a certain radio show, which will remain nameless, on a Monday morning from 9·00 am to 10·30, I believe that that would be the general perception.

Mr McKinney: Sorry, Minister. Some of these crises, such as the 90 GP queues, the accident and emergency scenarios and other crises within the health service, are consistent with the introduction of the plan, which did not get the funding that it needed, which did not fund the community side and which, in turn, is putting people back into the expensive end that you keep talking about, up the ladder. In other words, the plan has caused the problem.

Mr Wells: No. It is demand and the rapid rise in demand that is causing the problem. The stats bear that out. All the stats show that, particularly from autumn 2013, there was a spike in demand that has followed through in the system. Until that point, we were delivering within budget. All the stats show that there has been between 5% and 6% —

Mr McKinney: With respect, you cannot have your cake and eat it. A moment ago, you were telling us about how Mr Compton's report and plans would make a difference.

Mr Wells: Yes, they will eventually.

Mr McKinney: They have not made the difference, and you are not going to continue funding them to the level that they need to make the difference.

Mr Wells: We will continue funding them, and we want to fund them to the highest possible level.

Mr McKinney: You are not going to.

Mr Wells: It is not because we do not have the will.

Mr McKinney: That is not the point.

Mr Wells: If you have a £300 million shortfall, you have a major problem before you even address funding for Transforming Your Care.

Mr McKinney: I understand that. I could do lots of things with something that I wish I had.

Mr Wells: Yes, that is the practicality of where we are, and that was not envisaged when the report was published. It was envisaged that we would have similar financial structures to those of two and three years ago, but we do not. Demand has risen dramatically, and all of the trusts, even the most efficiently managed trusts, tell me exactly the same thing: they cannot cope with the increased demand and stay within budget.

Mr McKinney: I am trying to work out whether we are actually agreeing with each other and that the plan will not be funded —

Mr Wells: I will tell you this: if you look at the overspends in the five trusts, you will see a remarkable similarity. Some that came in below budget, until now, are finding it extremely tough to live within the present regime.

Mr McCarthy: The milestone in the Programme for Government for 2014-15 was to shift funding in line with the recommendation in Transforming Your Care: to move £83 million from hospital-based services to the community. Of course, the Minister will know how committed and passionate I am about the community. I am talking about people who need meals on wheels and those with learning disabilities etc. In 2012-13, £11·4 million was shifted. As yet, the Department has not been able to tell us or the world how much was shifted in 2013-14. Has that figure come to your attention yet?

Ms Thompson: The figure for 2013-14 is an additional £13·6 million.

Mr McCarthy: That is new to us. We have not been told about that. Are you telling us this afternoon that that is the figure?

Ms Thompson: Yes.

Mr McCarthy: How come the Committee was not informed of that?

Ms Thompson: My understanding is that it will need to come to the Committee. I know that the Committee asked that question, so I can confirm that. If you have not received that in writing, we will get that to you.

Mr McCarthy: What sort of money do you intend to shift in the next year, 2015-16, to carry out what you promised in respect of the £83 million that was to be shifted from hospitals to the community?

Ms Thompson: The shift in 2015-16 will be partly dependent on how much goes into transitional funding. Not all of it will depend on transitional funding, but we will move forward on that when we have a more realistic budget scenario.

Mr McCarthy: So, you do not know. You are driving in the dark.

Mr Wells: We do not know what our budget is.

Mr McCarthy: I know. You have said that.

Mr Wells: Kieran, considerable progress has been made on re-enablement across the trusts.

Mr McCarthy: Does it enable people to go to the shops or get a hot meal?

Mr Wells: It is to enable them to live more independently. Some trusts are almost completing that process as we speak. That programme has been one of the successes of Transforming Your Care. Eventually, it will mean that many people who, until now, have depended on various services will be able to live independently without them. That is a saving to the overall budget and an enhancement of their life.

Mr McCarthy: I hear what the Minister is saying, but I am not at all convinced by his answers to Fearghal on Transforming Your Care. Initially, we were all supporters of Transforming Your Care, but it seems that it is not doing what it was intended to do.

The former Minister threw up his hands in despair, and he was not in as desperate a situation as you are. You have told us that you are £300 million in deficit —

Mr Wells: That is next year.

Mr McCarthy: That is even worse. It seems to me that Edwin Poots saw what was coming and said, "I'm not delivering this". He went to his boss and asked, "Can you get somebody else who will?", and poor Jim fell into it. *[Laughter.]* You are the hatchet man who will cut meals on wheels and all the rest of it.

Mr Wells: Thank you for your concern about my position, Kieran. It is much appreciated. I know that you are really worried about me. Edwin made that statement before the outcome of the October monitoring round, and I am glad to say that we got the extra £60 million from the Executive.

Mr McCarthy: Did you get the £20 million? The last time you were here, you had not got it. You could not spend it, so you had not got it.

Mr Wells: We have not got it yet, but we will explain where we stand with the £20 million.

Mr McCarthy: This is crazy stuff, Jim — Minister. *[Laughter.]*

Ms Thompson: The £20 million is expected to come to us. It is conditional on our taking steps to balance the books. As far as we understand from DFP officials, it will come. We just have not received it yet.

Mr Wells: There are no conditions attached to the £60 million. We are getting the £60 million, and we will prioritise and spend it in the best way possible. There are no ties with that money, and it is coming.

Mr McCarthy: When will you get it? If it takes as long getting that as it is taking to get the £20 million, it will be this time next year.

Mr Wells: It will come in the normal monitoring round process, as is the case for any other Department. The Department of Justice, the Department for Regional Development etc also asked for money from the monitoring round. The £60 million is not an issue; we will get the money. We have £80 million to spend, but, remember, we are still £70 million short.

The Chairperson (Ms Maeve McLaughlin): Can we have clarification? You mentioned the shift left in the spend: £11·4 million in 2012-13, a lot of which was for resettlement in communities. You mentioned a figure for 2013-14 — was it between £13 million and £14 million?

Ms Thompson: Yes, £13·6 million.

The Chairperson (Ms Maeve McLaughlin): Can we have clarity on how that was spent? Will you indicate how much you might shift left in 2015-16?

Mr Wells: I will undertake to provide Kieran with the reablement figures for each of the five trusts. I saw them the other day. It has moved further than I had anticipated and shows just how seriously the trusts have been taking the issue.

Mr McCarthy: I understand, but, at the same time, will you let the Committee know how many people have not, because of that, received the community meals on wheels that they might well have been entitled to?

Mr Wells: The inevitable consequence is that some who were on community meals no longer require them. That is what the process was aiming for. In areas such as the Southern Trust, that process is very far on.

The Chairperson (Ms Maeve McLaughlin): Julie, were you going to comment on what I asked?

Ms Thompson: For mental health and learning disability resettlement, 2013-14 is in a similar place. In looking at the shift left in 2015-16, we will need to understand what is coming through from 2014-15 and 2015-16. I do not have a number to give to the Committee today because we need to understand what the 2015-16 budget scenario looks like before we can do that. However, we know that, as the Minister said, a lot of the work of the ICPs is moving forward. We expect that to come through even in 2014-15, but we are still finalising 2014-15 as well, given that the scenario of how much money we have was only recently clarified.

The Chairperson (Ms Maeve McLaughlin): OK. Will you come back to us on that?

Ms Thompson: Absolutely.

Ms P Bradley: Minister, I want to go back to look at the draft Budget. As you said, and as we all know, that has not been set yet. You said that there are definitely challenges ahead for the Department. You talked about the extra £100 million for 2015-16. Will you explain in a wee bit more detail how you came to the figure of £100 million?

Mr Wells: That is not our figure; it is a working assumption given to us by DFP. Had we been asked what our working figure was, it would have been £300 million or £400 million. Remember that, having floated the idea of the £100 million, DFP then said, "By the way, we're looking for £80 million to £90 million in pension provision". That would leave us with a tiny overall increase. We are working our way through the system on the basis of £100 million. If we get a surprise and are told that it is significantly more, it will be very easy to adjust our budgets to accommodate that — it will not be a difficulty. The £100 million is relatively in line with the 2% addition that we got last year. Under the comprehensive spending review (CSR), we got roughly 1·9% to 2%, so it is not wildly out of kilter to suggest £100 million.

Remember that, in the previous three years, monitoring rounds were more generous to us. We all know about the A5 situation. The A5 yielded £80 million to the health service. Most of that was in capital, but it was an extremely helpful addition to our budget. Other Departments will probably be ahead of us in the queue because they have taken quite a big hit as well. Even if we are entitled to monitoring round money, it will be the crumbs from the table. There is just no big project that anybody can identify that will yield a lot of additional money. I think that I am fairly safe in saying that, this year, we will get little or no extra cash because we have the £60 million and the £20 million.

Ms P Bradley: Therefore, if the Department gets the extra £100 million, will it be a case of getting it in one hand and giving it out with the other?

Mr Wells: That is still being looked at. Obviously, it is causing a huge problem. I know that DFP is looking at some way to ameliorate that huge hit in one go. To be honest, if it went through at £80 million to £90 million, we would, effectively, start with no extra money at all.

Ms P Bradley: Are you planning in line with sitting at the same level as we were in 2014-15? Have we looked at a scenario in which we get less? How would that shape up?

Mr Wells: Remember, if demand is going up by 6%, even base plus £100 million is less. No one round the table or in the Assembly has disputed that demand is rising by between 5% and 7%. That is what the cold hard statistics tell us. If demand increases by 6% and the resource budget increases by 2%, after three years of the CSR, huge strains will inevitably show, and that is where we are. We should not be surprised by that. Effectively, we are about 12% down because of the gap between what we are getting and what we are spending. I hate constantly going on about the budget, but it is a

very dominant issue. I would far rather concentrate on our great success in patient care, but the budget, and sorting it out, is the only show in town at the moment.

Ms P Bradley: Fearghal asked about the monitoring rounds. You pointed out that you will not be looking at the same amount when it comes to further monitoring rounds in 2015-16. Fearghal mentioned TYC, and you explained that the money for that was not originally built in. Should we be made aware of anything else that was not originally built into budgets and for which we rely on monitoring rounds?

Mr Pengelly: The Budget settlement of 2010 prescribed that our Department could access monitoring only for exceptional items. Therefore, by definition, we could not access monitoring round funding for anything that we knew about. The development of 2015-16 takes us beyond that. I would not presume to speak for where the Finance Minister or the Executive will end up, but, as difficult as the scenario that they have given us is, I suspect that they might say that it is slightly more favourable than what any other Department would get. By extension, they may well suggest that the same sort of conditionality applies: that we would be able to access monitoring rounds only for unforeseen issues. Our planning assumption is that we will try to deal with every issue that we foresee within the strategic prioritisation framework that the Minister sets and not hold out on anything on the assumption that we could access the monitoring rounds.

Ms P Bradley: So, the way it sits, you suspect that no money will come through, so you are planning nothing for —

Mr Wells: What Richard said is a reasonable assumption. I would be very pleasantly surprised if it were anything other than that. Obviously, we can foresee many of the problems that we will face. They are not unexpected, so we do not have the argument that they are unforeseen pressures. There is no pot of gold at the end of that rainbow, so we will have to live within a very tight financial structure. The basic working assumption is that we need £300 million to keep things ticking along. That builds in nothing for new services at all; it simply keeps things as they are, with no radical changes or development of a completely new level of services. The money will not be there.

That is being pessimistic. We do not know what could happen. There could be a change of Government in London or some change to the Barnett formula. New sources of income could be arrived at.

Mr McCarthy: Agreement on welfare reform?

Mr Wells: I was just coming to that. The parties around the table could reach agreement on welfare reform and so remove one of the great clouds hanging over us. We are assuming, by the way, that the Health Department will not suffer from the clawback on welfare reform. At the minute, we have been saved from that. Other Departments are taking, I think, a 4·5% hit on their revenue resource budgets. We have not had that; we had the 2% increase. However, it will get to a stage with welfare reform where the fines are so high that DFP may well turn its attention to the Department of Education and DHSSPS, and we will start to pay our slice of that. I hope that that never happens, but, if it does, we are in big trouble, because 40% of it will come from me. That is when the situation would become really serious.

Mrs Cameron: Thank you very much for your attendance today. I welcome you, Minister.

Mr Wells: Thank you, Mrs Cameron.

Mrs Cameron: I also welcome you, Richard. I had every confidence that Julie was going to keep you both right, but the Minister seems to be holding his own today, which is good.

You have answered this already, but, just for clarification, I want to ask about the level of efficiency savings that the Department might be required to make in 2015-16. What areas would you think about targeting, if further efficiency savings are required?

Mr Wells: Some may ask the basic question — I will head it off at the pass — of why, three years ago, I was saying that there was enough money and am now saying that there is not. One of the major changes is that, in the first three years, we were able to take £490 million of efficiencies out of the budget and transfer it to higher-level priorities. This year, we are asking the trusts for a very

demanding £170 million, and we will probably ask for somewhere in the region of £140 million to £150 million next year. That can be achieved by the more efficient use of resources. There has, for instance, been a considerable reduction in the overall average time that patients spend in a hospital bed, which is significant. Reducing that time by an average of 0·6 or 0·7 of a day per patient, without, of course, impacting on their care, leads to quite a significant reduction in the budget. Of course, that money is poured straight back into other forms of care. We have also gone further and further up the generic drugs ladder. We have adopted a policy of encouraging the maximisation of generic drugs, which can be 80% or 90% cheaper than their branded equivalent. Wherever possible, we are urging GPs, pharmacists and hospitals to go down that route. Our throughput in orthopaedics is also becoming more efficient.

All of that is well and good, and we need to keep concentrating on that. However, at that very high level — I think that the figure is £530 million or £540 million, but my sums could be wrong — it becomes more and more difficult each year to demand further efficiencies of the trusts. When you think about it logically, the low-hanging fruit has long since been picked and the soft options have been dealt with, so trusts are finding that they have to dig deeper and deeper to find further efficiencies.

In any budget of £4·6 billion or £4·7 billion, there will always be opportunities to find savings. In addition, centrally, through the board, for example, we require efficiency savings in administration. The burden has to be shared equally. I am a wee bit worried about pushing it much further than the £140 million because there are people in the trusts for whom I have the utmost respect. They, like Ms Thompson, are financially extremely able and are telling me that they are finding it terribly difficult. Why do I believe them? For the first three years, they were not saying that; they were saying, "We can do this with a bit of a push". Now, however, they are telling me, "This is terribly hard." Therefore, I do not believe that efficiency savings will be the solution to our problem; I think that we will have to find some way of raising money or getting more resources into the budget.

Mrs Cameron: Given what you are saying, it is even more important that we stop people reaching the hospital door in the first place. Keeping people out of hospital saves huge amounts, but that requires investment in other areas. Have you, in your 29 days as Minister, identified ways of working that have better outcomes for the same money?

Mr Wells: The issues that I outlined earlier will, undoubtedly, be the continual targets for making better efficiencies. Richard, maybe you could add a bit of meat to that.

Mr Pengelly: It all comes back to Transforming Your Care. We need to be very clear on the difference between the £70 million transformational funding that was needed and the £4·5 billion that is provided and spent each year on the provision of health care.

The availability of the transformation funding might have slowed a bit, but the strategic intent to take us forward on that path and to shift left continues. We are working with colleagues, and what I have been doing since the start of July, and the Minister has been doing in his 29 days, is engaging with staff at all levels, rather than taking the strategic top-down view from a nice office in the Stormont Estate on how we can change the system. We have been speaking to clinicians and other health service staff on the front line, and there are passionate ideas and enthusiasm out there. So, it is about grabbing those ideas, moving forward and continuing on that trajectory.

We talked earlier about engagement with GPs, and I have had two or three sessions with Tom Black, whom the Minister will meet tomorrow. Tom waxes lyrical about the federation model, and it sounds like there are huge opportunities in that. We are using the 2015-16 position to draw together the range of strands of work into a coherent plan to take us forward.

Mr Wells: It is worth saying that we have an increase in the budget each year of £35 million just to take account of the fact that we are all ageing. We can do nothing about that. The population of Northern Ireland plc is ageing inexorably, and that demands further budgetary allocations of £35 million. What can I do about that? I cannot make people more youthful.

Equally, there is the issue of the Public Health Agency and the fact that so many people in Northern Ireland who present themselves for care do so because of their lifestyle choices. The Committee produced a very interesting report on obesity. The graph on obesity and type 2 diabetes shows a positive gradient: the heavier you are, the more likely you are to get type 2 diabetes, which is an extremely expensive condition to deal with. If we could cut obesity dramatically, we would save tens

of millions of pounds. Cigarettes cause 2,300 deaths a year, and the related conditions are very expensive to treat, as well as being agonising.

We have 300 deaths a year because of alcohol misuse. It is a very worrying situation. A few months ago, the Chair and I met the cancer specialist in Northern Ireland. Northern Ireland is about to experience a major spike in liver cancer as a result of binge drinking. These are men and women in their 40s who were binge drinking in their teens and 20s. That is a totally new phenomenon. Until recently, liver cancer was an older person's disease. People who got it were usually in their 60s. It will be hugely expensive. If we do not deal with binge drinking, we will have one serious bill for seriously ill people.

Mr McCarthy: Can you give an commitment that, in order to save money, you will not go after the most vulnerable, namely, people with mental health or learning disabilities?

Mr Wells: I knew that you were going to ask that question, Kieran, as you always do.

Mr McCarthy: Absolutely.

Mr Wells: My major target will be to do what can be done to bring the budget into balance, with the least impact on front-line care, which includes mental health care. As you know, the statistics are very clear. Some say that we underspend by between 19% and 25% on mental health compared with the rest of the United Kingdom. That is one of the downsides of the joint provision of health and social care. We cannot go to the ratepayer to ask for more money for social service provision.

Folks, I have seen things that I believe can be cut without affecting front-line care. It will be interesting, even fascinating, to see whether Committee members will support me on that when the lobbying starts. I suspect that I will get a lot of letters from a certain office in South Belfast, and from other parts of Northern Ireland, protesting about those cuts.

The Chairperson (Ms Maeve McLaughlin): I am mindful that a number of members are waiting patiently to speak.

Mr G Robinson: First and foremost, I would like to thank the Minister for his excellent visit to Limavady two weeks ago.

Mr Wells: George, the office opened a book on whether you would mention Limavady in the first or second sentence of your question, and you did so in the first.

Mr G Robinson: Thank you very much. My question may be hypothetical, and you may have answered part of it anyway. Do you have any proposals for generating income for the Department?

Mr Wells: That is a good question — I can assure the Committee that there has been no collusion.

Mr G Robinson: It may be hypothetical.

Mr Wells: I will give you an example. Last Thursday, I was up in Londonderry, where there is a new catheterisation (cath) lab. It is a fantastic facility, and I was absolutely bowled over by what I saw.

Mr Dunne: They get everything up there.

Mr Wells: They have done well. We announced that the radiotherapy unit is going ahead as planned and will open in 2016, which is good news — I did not even get a smile from the Chairperson for saying that.

The Chairperson (Ms Maeve McLaughlin): I smiled previously.

Mr Wells: All the Foyle people made strong representations to me on that. We have spare capacity in that cath lab. At the moment, if people in Donegal need a cath lab, they have to go to either Galway or Dublin. One proposal may be that we make that spare capacity available to the people of Donegal at full cost recovery and bring in much-needed income. I strongly support that because, as you know, about one quarter of cancer patients in the radiotherapy unit will come from the Irish Republic.

Folks, there are other very difficult issues. You are aware that the previous Minister was looking at some form of administration or prescription charge that would, if properly implemented, yield significant income. I realise that these are difficult issues, but we will have to look at every opportunity to increase income generation. At the moment, what we bring in is a very tiny proportion of our budget. We have to look at using capacity and selling our services to our friends in the Irish Republic, the HSE. Should I be getting free prescriptions? I feel that I should not. I get a lot of prescriptions. When I go into my local pharmacy and get an expensive drug or pill but cannot pay for it, I feel positively guilty. I think that that is crazy, and we have to look at that. We will have to take the Executive and the Assembly with us on this, but there are ways of dealing with such issues that do not attack the vulnerable but bring in significant income.

Mr G Robinson: You mentioned that you will meet someone tomorrow to discuss GP services. I encourage you to have a wide-ranging talk, particularly about the out-of-hours service and so forth. I think that local doctors could be a wee bit more cooperative as far as the out-of-hours service is concerned. Maybe they could open on a Saturday morning, for example. You touched on things like that.

Mr Wells: The 2005 contract that the BMA signed with GPs and consultants is a UK-wide agreement. It was a child of its time. The Prime Minister, David Cameron, raised the issue of making GP surgeries more accessible. We are not asking for a huge change.

Mr G Robinson: Slight flexibility.

Mr Wells: Yes, flexibility. I suspect that it is inevitable that the BMA will say that there is a cost implication to doing that and will expect us to pay for it. I do not want to pre-empt what Tom will say, but I will be very surprised if he does not ask, "Where is the money to fund this?"

We have to move GP services into the 21st century. People now are tied up between 9.00 am and 5.00 pm and cannot get to their doctor. Employers are no longer sympathetic to letting them go. I do not see how one night a week or a Saturday morning would break the mould. That is the sort of issue that I want to talk to Tom about. I want a very good working relationship with the BMA because it is essential to delivery.

The Chairperson (Ms Maeve McLaughlin): I accept that we can look at doing things differently and at flexibility, but we also need to be mindful of the existing pressures in primary care.

Mrs Dobson: I welcome you to your first Committee meeting, Minister. It is a bit of a baptism of fire.

Mr Wells: Should I be very scared, Mrs Dobson?

Mrs Dobson: No, but Michael is speaking after me.

Mr Wells: According to your leader, I should be very scared.

Mrs Dobson: We will see as time progresses. I do not know what you have done to Kieran, but I have never seen him as annoyed or as animated. He is certainly not like this on the Agriculture Committee. I fully understand where he is coming from. Well done on your line of questioning, Kieran.

Mr McCarthy: The Minister knows me. He has been sitting with me for many years —

Mr Wells: Since the Boer War. *[Laughter.]*

Mr McCarthy: — as, indeed, has Julie.

Mr Wells: It is definitely not that long in her case.

Mrs Dobson: It will be no surprise that my line of questioning is also on Transforming Your Care. Fearghal outlined very eloquently a lot of what I was going to ask. I take you back to your briefing paper, where you describe Transforming Your Care as a three- to five-year journey. On the basis of

your answers to Fearghal, the journey has stalled a little. How confident are you that it is still a three- to five-year journey?

Mr Wells: If we are being honest, we have to say that it will not be as rapid as we expected. I keep coming back to the point that, when we first made that commitment, we could not foresee the current fiscal situation. I still think, as did the Assembly on many occasions, that the fundamental tenets of Transforming Your Care are the road that we must go down. In an ideal world, we would be further down that road by now. Your constituency has benefited from the new hub being built in Banbridge, which will be an excellent facility. It has been welcomed by the council and all constituency MLAs. We are providing hubs in Ballymena, Newry, Banbridge and — there is a fourth one that I cannot remember. However, we would like to have more of those.

Mr G Robinson: Is it Limavady?

Mr Wells: No, Limavady is not on the list, George.

Ms Thompson: It is Lisburn.

Mr Wells: Yes, Lisburn. Equally, although we are making great progress in the programme of integrated care partnerships — it has been a success, and we have 17 up and running — we would like that process to move forward. What encourages me is that, in areas that we have been able to fund, very considerable progress has been made. Our difficulty is that we just do not have enough in the budget, as it stands, to be where we want to be, and we have to accept that. Things might improve in year 4 and year 5, and we might have more funds to accelerate TYC.

Meanwhile, demand is rising inexorably and rapidly catching up on the efficiencies that we are achieving through TYC. In this business, you run very fast to stay still. We have been taken aback by the rapid rise in demand, even in the last financial year. Last autumn was the real tipping point, when things really began to move. Until August/September, the trusts were telling us that things were OK. Then, suddenly, the message was coming in from every trust independently that there was enormous pressure at every level, and that has stayed with us.

Ms Thompson: That is absolutely correct. Transforming Your Care is the reform programme that we need to be on. It is about how we commission services and the strategic direction required. The ICPs are under way and making some service changes, and the Minister talked about the reablement programme. Progress is being made, but it is not as rapid as we would have liked.

Mrs Dobson: It states here that it is a three- to five-year journey. I am asking because I had a meeting earlier with Valerie Watts, your new HSCB CEO, and Pamela McCreedy — I think she is the director.

Mr Wells: She is the lead on TYC.

Mrs Dobson: They almost hinted that it sounded as though Transforming Your Care would be a seven- or eight-year journey or possibly longer. That is quite alarming, given the answers that Fearghal got earlier, and it is why I was somewhat baffled when I read your briefing, which said that it would be a three- to five-year journey. Are they right that it would be seven or eight years or even longer?

Mr Wells: I keep using the word "re-enablement" when of course I mean reablement. Excuse the English.

Jo-Anne, just to confirm this, the TYC transformation programme board, which met in 2014, provided the programme with what is called an amber rating assessment on the status of the programme. It highlighted delays in agreeing finance as the key driver. I think, to be honest with people, that we are not where we want to be, but we are still committed. It may well take longer than anticipated.

Mrs Dobson: So, it may take up to 10 years, Minister. Is that more realistic? It would take seven or eight years.

Mr Wells: That is being a bit pessimistic, given that we have already had some success with delivering TYC. The five-year programme was based on an assessment of where budgets stood at

the time. I think that, had John Compton been able to use a crystal ball to see where we are today, he would have set a less demanding target. The group that is looking at this says that the status is amber, so they are saying, "Yes, we have difficulties". They are independent. They are saying that we have got a problem here.

Mrs Dobson: And obviously your senior executives, Valerie and Pamela, are hinting that it is a long way down the line — seven to eight years.

You have also said that we are still very much in the implementation phase, in your words, of the considerable change programme. Looking back now, do you feel that TYC was overoptimistic from the beginning with regard to what it wanted to achieve?

Mr Wells: I am looking back only 29 days. The previous Minister was the instigator, and rightly so. His first two announcements were that the radiotherapy unit would go ahead and that John Compton had been brought in to take on the work that became Transforming Your Care. I think that, if you asked him, he would say that we would have expected it to have been further on than it is, but there are very good reasons why that is not the case. It is not a lack of will; it is not a lack of quality in Pamela McCreedy and her team. It is just that we do not have the resources to do it.

Mrs Dobson: So, it was overoptimistic.

Mr Wells: It was not overoptimistic given the budgetary situation we were in when we made those plans. I did not envisage this. This time last year, I was sitting in this Committee totally oblivious to the head of steam that was building up. I was wondering where Julie was, but, apart from that, everything else was fine. Then, when we heard what was happening from the trusts, we were all taken aback by the sudden spurt in demand. That is what has left us in the present economically difficult conditions. John Compton and the Minister were absolutely right to plot that course given the information they had before them. They could not have known what was coming our way.

Mrs Dobson: Based on the meetings, they were a long way off.

We all know that the best laid plans can be tested by an emergency. With that in mind, how do you plan to build in contingency funding to cope with future medical emergency situations?

Mr Wells: That is a very good question, I have to say. Three years ago, we had the swine flu outbreak, which placed enormous stresses on the health service. We have been working very hard on the Ebola issue that is affecting west Africa. Fortunately, at UK level, the chief medical officers have taken that very seriously. Indeed, last week, I took part in a conference call with COBRA, which is the Government's emergency Committee. All the Health Ministers were linking with one another to ensure that we stop this awful disease getting to Northern Ireland. The budget is so finely balanced that something like this happening would place it under the most enormous stress and strain. I have to be honest and say that.

Fortunately, since the swine flu outbreak, we have not had any major pressure beyond the normal winter pressures that one would expect. I am hoping and praying that we do not reach that situation. If we do, then I think that we will have to go to the Treasury and say that we may need additional resources, as the other devolved Governments would do to deal with that. The present system is based on a certain level of expectation of demand. Anything adding to that causes huge problems. Maybe Richard can comment from a permanent secretary's view. He has done winter freezing, so he knows a bit about these situations.

Mr Pengelly: I will just say that, in the financial environment that we face, whilst it would be nice to set something aside as a contingency fund in the event that an emergency arises, we simply cannot afford the luxury of having some money sitting on a shelf not working for us as we go into 2015-16. We talked earlier about the monitoring round. Whilst we have no expectations about getting routine funding, there will be a monitoring process that we can access for exceptional issues. As with the swine flu issue, the Executive can intervene and take some measures, even intervening in other Departments, to try to release funding, with, ultimately, the issue going to the Treasury.

Mrs Dobson: Just to be clear, Richard; there will not be bids in the monitoring rounds for any pressures arising, with the projection that, in an emergency —

Mr Pengelly: Sorry: at the moment, we are not setting funding aside in the event that an emergency arises. If an emergency does arise, that will clearly be seen as being unforeseen and exceptional. If we assume that the current position is that those are issues for which we can submit bids, if that is rolled forward, then we would be allowed to submit bids for such issues as and when they arise.

Mr Wells: I think that if Ebola reaches the United Kingdom, a UK-wide decision will be taken to provide funding. We would certainly ask for that. Having sat in on the COBRA conference call and seen the way in which this is being dealt with, I can reassure you. The people who come from west Africa come mostly to places like London. I am hopeful that we can avoid this, but we have contingency plans, for instance, to take people to the Royal Free Hospital in London in the event of someone testing positive for Ebola. So, we are ready, but we are obviously all very hopeful that it just does not get to the shores of the UK.

Mrs Dobson: Finally, Richard, you are new to the role as well. I do not know exactly how long you have been in it. I know that the Minister has been in his role for 29 days. How many days have you been in yours?

Mr Pengelly: I started on 1 July 2014. I have lost count of the days now.

Mr Wells: He is a veteran.

Mrs Dobson: You have been there slightly longer. What role do you view the HSCB taking in the future? What are you doing differently from your predecessor?

Mr Pengelly: Maybe I have done this a bit longer than the Minister, but, at the moment, I am still engaged in trying to understand what is a massively complex system with a huge number of exceptionally talented and committed individuals in it. The board has a fundamentally important role with regard to the interface between the Departments and trust and as a commissioner.

Part of my role is to see better integration between the Department, the board and the trusts. I want to create a situation in which, whilst we all have our separate organisational status, fundamentally we feel part of the health and social care system in Northern Ireland and work together to deliver the best possible service that we can.

You mentioned that you met Valerie Watts. Certainly, one of the pieces of work that she and I have talked about is that she wants to look at the structures and role of the board from her perspective as the incoming chief executive. I think that it is fair that I allow Valerie the space to do that and engage with her on her initial views about the team and role.

Our commissioning system is a particular area that we need to work through and get the model to work more closely to the way it was intended to work and to do so in a way that is better for us and patients throughout Northern Ireland. There are issues to work on. It is certainly not the issue that we come in and say that the system is fundamentally broken and that we need massive surgery to the organisational structure. We need to get everyone aligned, looking the same way and working together towards the outcomes that individually we all share.

Mrs Dobson: I wish you well with that. Thank you.

Mr Dunne: Thanks very much. Minister, I think that we all congratulate you on your performance today. I reckon that you have got the job and got it for some time.

Briefly, the previous Minister put a big emphasis on prevention and preventative care, especially in the programmes that he had planned for that. Are they at risk with regard to the proposed management of the budget? How do you see them in your priorities?

Mr Wells: Of course, lots of the Minister's issues, for instance on tobacco control — point of display and vending machines — and the Sunbeds Act (Northern Ireland) 2011, have been implemented, and very successfully implemented, particularly in issues such as the smoking ban in pubs and restaurants, point of display and the whole issue of vending machines. They have been very successful and very widely honoured. One of his other proposals was for minimum pricing on alcohol.

That has stalled because one of the Scottish distillers has taken the Scottish Executive's decision to the European Court of Justice. Nobody can move until we get a ruling on that particular issue. If the court ruling goes in our favour, we can go forward with unit pricing, which is essential in trying to control the binge drinking issue that we have in Northern Ireland.

Some of the other suggestions are still in the system, as it were. Some have no financial implications, while others would require further expenditure. As you know, I place an awful lot of emphasis on the work that Eddie Rooney and his team in the PHA are doing. Most western societies would have a greater emphasis on that type of work. The former Minister Mr McGimpsey, of course, pioneered the establishment of the PHA, and a wise decision it was too. So, when it is —

Mr McGimpsey: You voted against it.

Mr Wells: Well, I —

Mr McGimpsey: So did he.

Mr Wells: With hindsight, it was a wise decision. *[Laughter.]* What I will say about it is that, because it is up and running for only a few years, it has not yet, in my opinion, got the full status it deserves. However, again, we are back to the funding issue; we do not have the resources to give it the full status it deserves. At the end of the day, people have to start to take their own decisions about their health. I am getting quite fed up with people telling me, "But that makes for a nanny state". Well, the same people, when they take terribly ill as a result of their lifestyle choices are quite happy for the nanny state to step in and spend tens of thousands of pounds to look after that condition. All of the evidence shows that when the state makes a commitment on public health and creates the right structures to encourage people to take lifestyle decisions, people do so.

The classic example is — I have said this before in the Assembly — if you go to a hard-bitten social club in west Belfast tonight, you will see six-foot tall men with skinhead haircuts, tattoos and earrings standing outside in the rain smoking, and this is probably the only law that they have obeyed in their life. Why? Because they respect the law that says you smoke outside in the street rather than in a pub or a restaurant. Adherence to this has been almost 100%. When society takes the lead and sends out a signal, people will follow. We need to educate and encourage our people to do things better. That is because we still have this terrible situation where if someone living in the Short Strand were to live at the top of the Malone Road he would live eight or nine years longer. It is not the air or the housing; it is lifestyle. Remember that the richest smoker will live, on average, for a lot less time than the poorest non-smoker. That is the issue that we have to address immediately.

Mr Dunne: So prevention programmes are a priority for you.

Mr Wells: They are absolutely essential.

Mr Pengelly: I will finish that point. The extensive work that we will be doing on the 2014-15 financial challenge and the preparatory work for 2015-16, as we move forward, will ensure that the PHA is fully engaged with us and the board as we go through to look at the issues, analyse them and bring them to the Minister to consider options for the way forward.

The Chairperson (Ms Maeve McLaughlin): OK. You are running the risk of stereotyping every person in west Belfast —

Mr Wells: Only those standing outside drinking clubs at midnight.

The Chairperson (Ms Maeve McLaughlin): We need to be mindful of stereotypes in all of this.

Mr Wells: Both sides of the wall.

The Chairperson (Ms Maeve McLaughlin): There are factors other than simply lifestyle choices.

Mr McGimpsey: I welcome you, Jim, to the Committee and to the job. It could not have happened to a nicer guy. *[Laughter.]* I also welcome Richard, who is new to the Department.

You tell a very familiar story. You are making efficiencies. You are finding £490 million, with £107 million to go. I did £700 million and got no thanks for it, but I did it anyhow because that is what you are supposed to do and it is part of the deal. I definitely do not want to dwell on the past, but also, in my time, there was no in-year monitoring for me. I could not get in-year monitoring funding; I had to do it on the money.

Mr Wells: But you got the first £20 million, of course.

Mr McGimpsey: Very large sums of money have gone into the Department through in-year monitoring since the last Budget. That money has kept the show on the road. Waiting times are slipping, and on another occasion I will dwell more on waiting times because they deeply concern me, particularly around cancers and in A&Es.

The in-year monitoring then stopped, and Edwin told the same story that I did — and you are now telling it too — "there ain 't enough money". I think your line was that you do not have enough money to fund the basics of life. That is where we are. I am very sympathetic to you and, because I know where you are, were you to table a motion I would vote for you to get more money. You are in a position of transition, and TYC, which I called shift left in my day, is one of the key answers, but it needs major investment and you do not have the money. I accept and understand all that.

What I am looking forward to is the coming period. If you have no monitoring money coming through, then you do not have enough money, and your gap is £300 million. As far as I can see, having been involved in discussions and so on, the money is not going to be there. Sadly, and tragically, it is not going to be there. So, unless other Departments give up money to you, and they already have major gaps to fund, you are going to have serious decisions to make.

With a Department, as I know and you now know, your options are very limited. You can cut programmes or jobs; you can sell assets or start raising income. The question I am interesting in, because you do not have enough staff to do the job at the minute, is where the axes are going to fall. What is the balance between cutting jobs, cutting programmes, raising income and asset disposals, if you can sell anything?

You are going into this new budgeting process. This year sees the end of the four-year Budget, which is a difficult time. You are now going into the last year of the Assembly term and into the first year of the next four years, and the money is in trouble, so the Department is in trouble. The issue is how you trim, because you have to cut back. You are getting ring-fenced but demand is rising, so where is the axe going to fall?

Mr Wells: First, Michael, I thank you for the very supportive interview that you did when Edwin was in post. You analysed the position he was in and indicated a fair degree of sympathy for him. That was appreciated.

Equally, what you say today is an adequate summation of where we are. We have a large asset bank but, as you know, because of the recession we have not been able to realise much of that. The difficulty is the DFP rules. Even if we did sell assets, the money would go back into the centre and we would bid for mostly capital projects. It is not usually available for revenue, for obvious reasons.

In the difficult time we are in, we are going to have to look at revenue-raising. If that does not bridge the gap, we have to be honest with our Executive colleagues and say, "We are going to require a larger slice of the cake". The difficulty with that is that because health is such a huge proportion of the overall expenditure in Northern Ireland, to take an extra 2% or 3% out of the Budget and give it to health involves severe pain for the smaller Departments. That is assuming, of course, that you no longer protect education.

We would have terribly difficult decisions to make. We would end up having to curtail. Things such as orthopaedics and elective care would be harder to get, and waiting lists would grow. We will certainly try to drive down expenditure in pharmacy. At the minute, it is between £500 and £600 million per year. That is a huge proportion of the budget.

Mr McGimpsey: Between £500 and £600 million per year in pharmacy.

Mr Wells: Two thirds is in the community and the rest is in the hospital sector. We are going to have to go back and grind down the proportion of generics even further, which will create concerns among

constituents. It will be painful but if, at the end of the day, extra money does not come from Westminster or through revenue, we will be forced into making even further efficiencies, and that is difficult.

We do not know the new funding scenario after next May. We do not know who will be in power or what they are going to do. That could, potentially, be a way forward but, yes, I have to say that it is looking gloomy. I am being absolutely honest with you.

You and I and this Committee will spend many hours talking about this issue; something that did not dominate the Committee at all in my first three years on it will become very much an issue of concern. I think it is realistic for the three of us to flag up what we see coming, namely that it is not good news, so that everybody out there realises the difficulties we are in.

Northern Ireland generally will be in difficulties because this applies to other Departments as well, which do not have the protection that we have. Remember that the health element of our Budget is protected in the sense that we get a 2% uplift, but social care or public safety are not protected. That has given us some protection but other Departments had to take real cuts already this year and in the previous two years. So, we are going to work through this and see what we can do. If there is anything I can take out of the budget that will not affect the treatment of patients, I will be very keen to take it out.

Mr McGimpsey: You are talking about income and raising income. I presume you are talking about prescription charges. There is very little money in that. What else are you talking about?

Mr Wells: There is £17 million.

Mr McGimpsey: There would not be.

Mr Wells: I can understand why you say that there is very little money in it. There were so many exemptions that, by the time you collected the money and did the administration, there was not a huge residue left. There are other models worth looking at, as far as prescriptions are concerned, rather than the old one. Again —

Mr McGimpsey: But you are still going to have those exemptions. You cannot charge babies; you cannot charge old folk; you cannot charge people with long-term conditions.

Mr Wells: There are proposals, and they are having difficulty with the Executive. I accept that it is a cross-cutting issue, and it is unlikely that we are going to get support for it, but we are going to have to start looking at every possible revenue.

Mr McGimpsey: You are not looking at things from the Irish Republic, like charging to go to the GP and A&E and for a hospital bed.

Mr Wells: No. The principle must still be that hospital health care provision is free at the point of demand. That is the UK-wide system that we have, and we will not be stepping out of that basic tenet. There are other ways of raising money that do not breach that principle.

Mr McGimpsey: I would like to know what they are.

Mr Wells: We are looking at them. When we have proposals, we will bring them to the Committee. They have to be consulted on at Executive level, and there has to be a full public consultation on the ideas.

Mr McGimpsey: We agree most of the efficiencies that you are going to get. The low-hanging fruits are away, and I do not see much mileage in the generic drugs, because drugs become generic after 10 years. That means that if you go all-generic, you cannot touch any drugs that have been invented in the past 10 years. There is a balance.

Mr Wells: But each percentage point we move up the generic rate saves £6 million.
Mr McGimpsey: I know that. You have inherited the 'Go Generic' policy. I am very familiar with it.

You are bound to have looked at where the cuts are going to fall. What is the percentage of cuts? What is the percentage with regard to income raising? What is the percentage regarding asset disposal? You have to find £300 million. You have told us that.

Mr Wells: We did not know that we were going to get the £60 million until two weeks ago. People are saying, "Why haven't you given full detail as to where we are going in 2014-15?", but we did not know where we stood. If I had not got the £60 million, today would be a very different story. Equally, we need to see how that extrapolates through this year's budget before we plan for next year. We are still discussing next year's budget. When we do, the Committee will get full details and an adequate opportunity to look at it.

Mr McGimpsey: When do you think that will happen?

Mr Wells: We have to be well through the budgetary process for 2015-16 in this calendar month.

Mr McGimpsey: We will leave it there in the meantime; I think it has been well and truly explored.

You started with the GPs. Some 25% of our GPs are over 55, and we have the lowest rate of GPs per population in the UK. That is one of your problems for TYC. How do you plan to address that and to deal with all of those inevitable retirements that will come very soon?

Mr Wells: The Department is very aware of that. We are having the workforce review to look at that sort of problem. If we go on the way we are going, we will not have enough people willing to be GPs.

Mr McGimpsey: When I was in your shoes, I increased the throughput through Queen's medical school by, I think, around 100. The first cohort came out in 2013. What success are you having with getting those doctors, as they are trained, on to primary medicine as opposed to hospitals?

Mr Wells: Something that you could not have foreseen has happened: a large number of those people are going to Australia and Canada to take up lucrative contracts in hospitals. We are losing about 50 doctors a year to those two countries, mostly to Australia. They are paid significantly higher there and, for the most part, are in brand new health facilities. We had hoped that, after having done a few years there, they would return, but the evidence indicates that a lot of them are staying. So, we have lost the benefit of the increases that occurred during your tenure, and we are going to have to look again at the number of graduates.

We also have to look at this issue: do we spend a large amount of money training people to such a high standard that they can transfer their skill anywhere in the world, only to lose them? What worries me is that some countries are looking to recruit nurses from Northern Ireland as well. That is a terribly difficult issue. One area in which we are under huge pressure is doctor provision, particularly middle-grade doctors. Hence the decision to limit cover in such places as Downe and Lagan Valley. We simply did not have enough doctors to cover the entire country.

Mr McGimpsey: All of that is true, and I am sure that there are ways to address that. After all, for years, we have relied on doctors from India coming to us. Doctors move, but it does seem illogical that, if you increase the number by 100, as we did, you lose half of them to Australia. We are not here to train doctors for Australia. That is a concern, and I am not really hearing an answer there either. No doubt, you will warm to the subject.

Mr Wells: We will wait until the review of workforce planning to decide what we will do.

Mr McGimpsey: The City Hospital A&E is close to my heart. It was shut down on a so-called temporary basis for a consultation and so on and so forth. It is a hospital that was running at nearly 50,000 visits a year and was doing well with its targets, and that has disappeared. I want to know what is happening. I have never got an answer to say that it is closed for good. As I understand it, you are still considering reopening it.

I put it to you that the four-hour waits and the 12-hour waits at the Royal Victoria and the Mater have rocketed since the City Hospital shut. Again, that is something that we will return to in the future. At the Royal, 95% of patients should be seen within four hours, but, instead, we are way down at 64%. That represents tens of thousands of people every year. That is surely an argument that it was a mistake to shut the City Hospital A&E. It has the staff available, so get the City Hospital A&E

reopened, not least because prison officers, soldiers, police and their families are uncomfortable going to the Mater and the Royal. How will you address that? They are all rushing to the Ulster if they need to go, and there is a skew there.

Also, the critical care building, which I ordered at a cost of £150 million or £160 million, is sitting there, and it includes the regional maternity unit. I still see the building. It looks like it has been finished for years, but there is nothing happening there. What on earth is happening with that?

Mr Wells: I will ask Julie and Richard to reply on the issue of the critical care building. You will understand why one of the first decisions that Edwin Poots made was to, effectively, close A&E at the City and move it to the Royal and the Mater. That was not based on a financial consideration at all, but on the fact that we could not maintain adequate coverage of the senior clinicians that we needed to man an A&E unit at the Royal, the Mater and, of course, the City. The latest on that is that that is still the situation that we are in. If we were to open the City A&E tomorrow morning, we could not staff it. There are legal impediments that we have to adhere to in that, if we do not provide what is recognised as adequate levels of coverage, we have no choice but to close.

Mr McGimpsey: You have a pool of about 600 middle-grade doctors.

The Chairperson (Ms Maeve McLaughlin): Minister and member, I am going to move this on because I am mindful that the Department will be here in November to deal with the regional task force on unscheduled care. Today, we are on the 2015-16 budget. Whilst it is an important issue, we need to stay on topic.

Mr Wells: We need to deal with the critical care building. Richard has some information on that for Michael.

Mr Pengelly: This may be a week or two out of date, but the last information was that there were some significant problems with the water system. Extensive remedial works have been done, and at this stage, we are still not prepared to accept handover from the contractor. Dialogue is ongoing, and I have to say that my sense is that that dialogue is becoming more and more difficult. It is a huge frustration to us that —

Mr McGimpsey: You have paid out a lot of money.

Mr Pengelly: We have, but a lot of extensive remedial work was done by the contractor at no cost to us. We are continuing to push, but, as you rightly said, there is frustration that the building should have been commissioned, handed over and be in service by now.

Mr Wells: It is worth saying that there is roughly £236 million in the capital budget for this year and, I think, something like £238 million as a projection for next year. We are adhering to our commitments in all those commitments. We probably have very little room to go beyond that, but we are committed to the Ulster Hospital, which I know is close to the heart of Mr Dunne, Altnagelvin, Antrim and the hubs, sometimes contractually because we have to be. Last Thursday, I was at Omagh laying the first stone, as it were, for the new enhanced hospital. So, those projects continue. We do not have much room to expand on them, but we will deliver what we have already committed ourselves to.

The Chairperson (Ms Maeve McLaughlin): I thank all three of you.

Mr Wells: Madam Chair, you rightly picked up on a phrase that I meant rather facetiously. My comment would apply to any working, Rangers or Celtic pub or loyalist club anywhere in Northern Ireland. I was not particularly homing in on west Belfast. I was trying to make the point that the adherence of every community in Northern Ireland to the smoking ban has been almost 100%, and that is to be applauded. I was not trying to denigrate the people of west Belfast in any way.

The Chairperson (Ms Maeve McLaughlin): OK. Thank you. Hopefully, this is the shape of things to come in these discussions. It is important to reflect on the themes that you have outlined on strategic priorities. What I hear as Chair is an intention to keep existing services as opposed to putting a priority on new ways of doing things, and that is an issue for the Committee in our deliberations going forward. I suppose that part of this discussion is very much around services being demand-led. Part of the conversations that we need to have with you is around the reasons why there is an increase in demand and how we look at doing things differently in and around that. Thank you for your

attendance today. The Committee will reflect on the evidence given and will, no doubt, continue the conversation.