Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

October Monitoring Round: DHSSPS Briefing

25 September 2013

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

October Monitoring Round: DHSSPS Briefing

25 September 2013

Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen

Witnesses:

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

The Chairperson: I welcome Catherine Daly and Julie Thompson to the meeting. I hand over to them for a 10-minute presentation, and then I will open it up to questions and answers.

Ms Julie Thompson (Department of Health, Social Services and Public Safety): Thank you for the opportunity to provide evidence to the Committee on the Department's participation in the October monitoring round. To start, it will be helpful to recap on key points in the process. First, as outlined in your briefing paper, the Department has been granted certain flexibilities on the management of its budget, which are not available to other Departments. Those flexibilities mean that, when it comes to monitoring rounds, the Department's participation is different from those of others. We are not permitted to table bids for current expenditure, except in the event of major and unforeseen circumstances, and neither are we expected to declare reduced requirements. Secondly, any allocations made through monitoring rounds are typically non-recurrent in nature. That means that such funding must be used in the current year and cannot be carried forward into future years.

Against that background, I will outline the Department's proposed approach to current expenditure and capital expenditure. In determining our approach to current expenditure, we have considered a range of factors, including the financial position for 2013-14. As previously highlighted to the Committee, the Department, the board and the trusts have been working closely to identify opportunities for delivering cash-releasing and productivity improvements in order to address the full range of financial pressures in 2013-14. However, we still have a funding gap, which we are working hard to address.

Given the significant level of savings that are required to be delivered in 2013-14, we are proposing to submit current expenditure bids in three areas: £18·7 million for transitional funding for Transforming Your Care (TYC); £26 million for elective care services; and £20 million for clinical negligence

settlements. Our assessment is that it is not possible to fund those initiatives from existing budget allocations without having a detrimental impact on the quality and standard of services for patients and clients.

The TYC report estimated that £70 million would be needed over three years to pump-prime a number of key transformational changes to the way in which Health and Social Care (HSC) services are delivered in Northern Ireland. Members will recall that the Department received £19 million from the Executive in 2012-13 to fund TYC transitional costs and other HSC savings initiatives. In addition, a further £9·4 million was received in the June monitoring round. The proposed bid for October monitoring represents the proportion of the overall bid that was not successful in June monitoring. The remaining £18·7 million bid for the transitional costs is required to support service transformation in 2013-14. That includes support for carers, a range of re-enablement initiatives and the implementation of a voluntary redundancy/voluntary early retirement scheme across HSC. Our assessment is that such a scheme is necessary in 2013-14 as staff turnover alone would not provide a sufficient skills mix to allow the transformation on the scale and complexity envisaged by TYC.

I move now to elective care. Additional investment is needed at this time in order to improve performance across a range of regional specialties, including orthopaedics, general surgery, gynaecology and ophthalmology.

Our assessment is that additional non-recurrent funding of £20 million will be required to address the financial pressures arising from the settlement of clinical negligence cases in 2013-14. That is because some £28 million has already been incurred to date in 2013-14, compared with the full year out-turn of £26 million in 2012-13.

As the briefing paper sets out, there has been a significant increase in the number of individual cases settled in excess of half a million pounds. Our assessment is that all those bids can be considered as both major and unforeseen in the context of the October monitoring round and that, as a consequence, under the terms of our participation in monitoring rounds, we are permitted to submit those bids.

Turning to capital expenditure, we have been working closely with the trusts on the overall level of in-year capital pressures. In doing so, we have assessed the timescales for business case preparation, procurement and construction, and have concluded that there would be insufficient time to spend any additional funding in this financial year. As a result, the Department has not proposed to submit any capital bids in October monitoring.

In conclusion, given the current financial position, our assessment is that it is not possible to fund those additional recurrent pressures from existing budget allocations. The TYC transitional costs and the elective care bids will help to continue the necessary reforms in Health and Social Care services and significantly reduce access times for a considerable number of patients, while the bid for clinical negligence settlements will help to address that significant in-year financial pressure. We strongly recommend, therefore, that these bids be considered favourably by the Committee and the Executive.

We are happy to take questions from members on any of the issues raised.

The Chairperson: Thank you for the update, Julie. I think that this is appropriate. The Department has discussed its monitoring round bids with us previously, and I welcome the fact that we got the paper in advance this time. We do seek clarification and further detail on a number of issues.

I refer, first of all, to the issues that were covered quite publicly last week. This relates to the Western Trust in particular, but I am not suggesting that it is the only trust affected. There is a public aspect to this because the Western Trust is being asked to make savings of £4·6 million. The list of potential savings is very stark. The trust talked about the impact of the savings on the delivery of core activity to meet service and budget agreements and on patient flow. It said that the nine-week waiting list would not be delivered and that appointment processing and waiting lists would be affected. It suggested that there would be a direct impact on the current population of service users, that quality of care would be compromised, and that there would be an impact on discharges from hospital. One of the targets for potential savings is to reduce funded nursing by 25%, which the trust said would result in the closure of up to 24 beds.

Therefore I am asking the Department — I am being very careful to point out that this is one trust and one example — to clarify what savings are being required or requested of trusts. What is the process for making those savings, and what impact will they have? Quite honestly, from reading the

correspondence from the trust to the Department, I think that the impacts are quite stark, particularly on front line services. I am asking this direct question: in the current climate, what are the total savings being requested and how will they be managed?

Ms Thompson: The Department has to deliver £139 million of savings in 2013-14, the trust element of which is about £78 million. The trusts are working hard to identify that and to put in place savings plans.

The document that you describe reflects the fact that the Western Trust and indeed all the trusts have deficits currently forecast in their financial positions. Those are on top of the savings plans that trusts have already been asked to deliver. Those deficits were forecast to be £31 million in total. We are working through a process with the regional board and the trusts to identify the scale of the deficits and why they have arisen and, then, the proposals needed to bring every organisation back to a financial break-even position.

The document that you describe is a step in the process, although it has not been accepted by the regional board or the Department. The trust, like all trusts, has been asked to go back to the drawing board, understand exactly what caused the deficit and articulate what it has to do to live within that resource. That is the context of the paperwork that you saw. We hope to work through that process in the next couple of weeks with the trusts and the board and, therefore, understand exactly what is needed to bring our organisations back to financial break-even.

The Chairperson: What was presented publicly about where those savings were to be found was almost a done deal. If it is not accepted by the Department or regional board, we need to get a sense of what that process will entail because it will not be the only trust required to find those savings and even deal with deficit issues. It is appropriate that an impact assessment be done across the trusts on some of those decisions. The closure of 24 beds in the current climate is stark.

Ms Thompson: You are quite right: it is not just a Western Health and Social Care Trust issue; it is across all trusts. The process is being worked through clearly with the board and the trusts to articulate the scale of the deficit — why it is there, what is creating it or whether it is due to new pressures or slippage in savings plans — and then identify what it would take to break even. We will need to assess those, as will the regional board. The Minister will need to take a view on what comes back from that process, but the process is still working through. The proposals that you saw are early drafts and have not been accepted at this stage.

The Chairperson: I request that that information be fed directly to the Committee as well so that we get sight of the overall picture and the potential impact and so that our views will be taken into consideration.

Mr Beggs: When are they savings and when are they cuts? I met the parents of a severely disabled adult whose respite care has just been cut in half. The reason given was that the trust had to make savings. It was not about their son's health having improved or circumstances having changed; it was simply cuts. How are you getting a handle on what is happening in each trust?

Ms Thompson: The trusts' savings plans are not to be to the detriment of front-line care. They will be looked at by the regional board in the first instance and then by the Department after the regional board has scrutinised them. That is the advice given on all the savings plans. The financial position is exceptionally challenging; the scale of the bids that we are logging in October monitoring is testament to that. However, we need to understand what those savings plans are and then understand what is happening on the ground. I share your concerns about that example.

Ms Catherine Daly (Department of Health, Social Services and Public Safety): It is not helpful to see the proposals that you referred to in the letter in isolation, Chair. When they are assessed, as Julie said, there is the financial context, but the assessment is in the context of safety and the delivery of services to patients. That would be at the forefront of our assessment. I want to assure the Committee that that is how they will be assessed.

The letter mentioned the potential closure of beds. In certain circumstances that is not necessarily a bad thing; however, it has to be set in the context of what leads to the closure of beds. You mentioned respite care and other issues that ensure that services are available to patients. That is the thrust of Transforming Your Care: the transformation programme to ensure that there are proper services in place where they are needed. We talk about the shift left and the intention behind it. It is a complex

process, and those assessments will be across the Department with the board and the trust in the context of the safety of patient services.

The Chairperson: We are agreed that that information will come back. No decision has been taken in the Department or the regional board, and any overall assessment will be brought back here for our scrutiny.

Mr D McIlveen: I should have declared an interest in this meeting. I was recently appointed as Assembly private secretary (APS) to the Minister of Finance. Therefore, Julie, it is very possible that I will be meeting you in a slightly different environment to discuss this further.

Mr Wells: It will be nice to.

Mr D McIlveen: This has not arisen before, because the last APS to the Finance and Personnel did not have a Committee position. I am happy to take your guidance on this, Chairperson. I am also happy to take the guidance of those who are giving evidence, as they may wish me to absent myself from the rest of the session. I am entirely in your hands on that matter.

The Chairperson: The Committee Clerk has advised me that she will seek guidance on that. We will follow up on it.

Mr D McIlveen: Would you prefer that we play safe for today's session?

The Chairperson: If you are comfortable with that, that is probably the wise thing to do. You do not have to leave.

Mr D McIlveen: You are happy?

The Chairperson: You can stay, but there will be no questioning from you.

Mr D McIlveen: I will remain silent.

The Chairperson: Julie, you talked about bids for exceptional circumstances in the monitoring rounds. You also referred to the major and unforeseen circumstances that allow Departments to bid in monitoring rounds. It begs a specific question around waiting list backlogs. This is not new. The briefing paper that we got shows, for example, that there has been a dramatic increase — from more than 19,000 in March to more 34,000 in June — in the number of people waiting more than nine weeks for an outpatient appointment. We have had bids to address the waiting list issue since October 2011, which begs this question: is that unforeseen? The fact that there have been bids for that since 2011 suggests that it is not. Does the Department have a strategy to deal with this issue as opposed to just making bids for funding in monitoring rounds?

Ms Daly: Our view is that it falls into the category of major and unforeseen circumstances. The extent of the increase in demand has been much greater than anticipated. A number of factors contributed to that. We secured £19 million of additional funding in the past year to address the waiting list issue. That has been helpful and has helped to reduce waiting lists to a degree. There was a significant improvement last year, but there has been a deterioration since March.

The board is working hard to address that issue. A combination of factors contribute to it. One of the issues highlighted is the fact that GP referrals for assessment and treatment rose by 6% last year and a further 4% in the first six months of this year; those are significant increases. In the whole of the health budget there is a recurrent gap of some 65,000 to 70,000 outpatient assessments and 15,000 to 20,000 in-patient day-case treatments across all specialities. Most of that will be addressed from within the board's own resources and existing budget. However, the additional £26 million that has been bid for in this round is required to augment existing services. It will fund the 24,000 additional assessments and treatments that are over and above the core capacity that exists in the Health and Social Care service.

The Chairperson: So is there a strategy?

Ms Daly: There are ways of addressing it, such as more efficient working. In some areas, there are recruitment issues. A number of factors contribute to the extended waiting list. The Health and Social Care Board is engaging with the trust to develop plans to ensure that waiting lists are brought down. This is the focus of significant attention within the Department and between the Department and the board in respect of its performance management responsibilities. However, performance management is just one issue. As I said, there are a number of issues that contribute to this that are not to do with performance. It is about increased demand, and the board is looking at ways of dealing with that.

To pick up on Transforming Your Care, one of the issues under the transformation programme is to ensure that — I do not want to use what sound like clichés — people are getting the right treatment in the right place at the right time. That is about ensuring that there are fewer admissions, proper referrals, and processes in place in the primary and community sector so that people do not need to attend hospital. There is a strategy at a very operational level with the board. There is also the bigger strategy in the context of the transformation programme, as this is part of what it will address. However, there is an immediate core capacity under-funding issue here. This cannot be funded and addressed from within the current capacity.

The Chairperson: One of the bids is in and around £11·7 million for what is called voluntary retirement or early redundancy. Looking at this in more detail, it seems to me that £0·5 million is allowed for rehiring and training some of the experienced staff that the Department is losing from the system, for want of another description. It seems to me that that is another case of firing and rehiring. Do you have a view on that?

Ms Thompson: Do you mean the £0·5 million related to the workforce reskilling element?

The Chairperson: Yes.

Ms Thompson: That is to provide a bit of investment to help transition and to take, for example, acute services into the community services. It will take money to fund that, and that is the £0·5 million. On top of that, the £11·7 million is to do with voluntary redundancy. So, those are two separate, distinct elements of the bid, both of which are about how you deal effectively with workforce transition through a period of change.

The Chairperson: Would it not make sense to retain the staff and expertise that is currently there and retrain them in the specifics that are required as opposed to giving voluntary redundancy or early retirement and then rehiring?

Ms Daly: Absolutely, and that is the first thing to do in the workforce planning. As regards the changes that take place, different staff will require different skills. Some people may be able to move and be retrained, and that is part of what will be done under the programme. However, there will be staff reductions in this process. We anticipate that that reduction will be in the region of 1% of the workforce and that it will be made through voluntary redundancy or early retirement. If staff with the appropriate skills and training need to move, that will be facilitated in the whole workforce planning programme.

As regards the whole workforce, the estimate since the beginning of this process, which remains the estimate, is that a programme of voluntary redundancy and early retirement will be required, and that £11·7 million is part of the profile that was anticipated across the three years. However, where skills exist and can be retained, that will be done. The trusts are working on detailed workforce planning, which will follow on from the investment proposals that the board is looking at across all the elements of TYC. As things move on, we will get more clarity on where those changes will be made. However, retaining skills is accommodated and will be built into the programme.

Mr McCarthy: David will remain silent, but I can assure the Committee that I will not remain silent now or in the future. I am totally disgusted by what I heard from my colleague Roy Beggs about the reduction in respite services for the most vulnerable people in our society. I hope that you can take back a strong message from the Committee that we are all singing from the same hymn sheet and that the respite facility for people with learning difficulties or disabilities has to be increased. In fact, on a number of occasions, the Committee has heard the Minister and other senior officials say that there would be continued respite facilities. So, I do not want to hear from any other member that there will be cutbacks on that. I speak from experience; we depend on respite in our family. For it to be reduced is not acceptable.

Ms Thompson: I re-emphasise that the proposals are early drafts. They have not been agreed either by the board or the Department at this stage. I can certainly understand the Committee's concerns about what was described by Mr Beggs.

Ms Daly: Again, that is a key element of the strategic programme for the entire health and social care service. We talk about care being provided near the home. That includes ensuring that there are proper facilities in place for both patients and carers. I was trying to pick up a specific piece of briefing that I have on this issue; I just cannot pick it up. However, the issue will absolutely be addressed. As Julie said, none of those plans has been approved. They will all be considered in that overall strategic context.

Mr McCarthy: As long as you people have got the message loud and clear that a reduction in respite care for anyone in our community is not acceptable. That is important.

I have a couple of questions. You talk about other service changes and your intention to spend £0·8 million on further telecare support and support for Bamford review changes. Can you give us more detail on the Bamford review changes that you expect to fund? As you know, Bamford has been on the go for quite a while. It has not been fully implemented. I am interested to hear what that £0·8 million will do now to further it.

Ms Thompson: Perhaps, I could make a start on that. It is about looking again at caring for people more in the community environment, which is, as you know, consistent with the Bamford model. So, it is looking at crisis-response teams, putting them in place and expanding them in the community. Support for telecare is also proposed in that £0·8 million. What I would say is that this is just the element of the bid in October monitoring. There is, obviously, investment in the existing baseline of funds in the relevant programmes of care. It is proposed that they will go up by nearly £30 million with investment that is going in. So, the £0·8 million that you see is very much the tip of the iceberg compared with what is actually invested across the existing health and social care system.

Mr McCarthy: On mental health resources, can you tell us what evidence there is to show a shift of resources into mental health to address the relative underfunding that we have here in Northern Ireland compared with the UK average?

Ms Thompson: We expect the resource investment in mental health to go up by some £14 million. There will also be expected efficiencies, as there will be from every programme of care. When I have been with the Committee previously, we have talked about how investment in community services is increasing in mental health and investment in hospital services is decreasing. I do not have those figures available to me right now. However, I know that we have explained to the Committee in the past that you can see very clearly that, for mental health, that investment in the community, which is very much at the heart of Bamford, is very much happening in the figure work as we look at it across the piece.

Mr Brady: Thanks for your presentation. I have a couple of questions. In stroke services, £2·4 million is being spent to retain five staff for another year. According to what we have been told, those five staff were recruited in the trusts in 2012-13. That extra money is to maintain them in place in 2013-14. Are they on a 12-month contract only?

Ms Daly: I cannot give you an answer about the extent of their contracts at this time. However, I can clarify that for you.

Mr Brady: I am asking because I want to know why, if they have not delivered what they were supposed to within one year, they need another year. If they are in 2012-13, was that not budgeted for when they were appointed? An amount of £2·4 million to keep five staff seems fairly excessive. Are they in very high grades, or are there other costs associated with them?

Ms Thompson: I will make a start on some of that. That is only part of the bid. The remainder of the £2·4 million is about having nurses, physiotherapists and speech and language therapists in the community to help with discharge from hospital. It is certainly not all going on five members of staff.

With regard to it being in place from 2012-13, that was a feature of our bid for TYC last year, and, going into 2013-14, those services are still required as part of the transition for TYC. It is part of the

£70 million that was included in the TYC report as transitional funding, and this is the 2013-14 element of it.

Ms Daly: That money is non-recurrent, which is why we need to bid for it again now.

Mr Brady: The elective care backlog is £26 million, and the negligence settlement is £20 million. The Minister is asking for an additional £26 million to address a backlog in elective care and another £20 million for negligence settlements. There have been reports that indicate that those issues centre on staff resourcing or lack of staff. To clear up the backlog, surely more staff are needed, rather than fewer. If you have fewer staff, you are going to create more problems.

It seems to me that incurring unacceptable waiting lists is going to be a progressive problem. Presumably, there are negligence claims because people feel that they were not treated properly, for whatever reason. Fairly recent reports have linked that to a lack of staffing levels. Do you see a correlation there?

Ms Thompson: I will pick up the clinical negligence issue. What hits the budget, and what we require funding for, is the settlement of the clinical negligence cases. Those cases tend to be ongoing for a considerable time, so you would not get a direct relationship between what is happening on a service today and the settlements that are going through the books. I understand the point you are making, but there is no direct correlation on that. This is coming from past actions, and we are looking at a piece of work around how to avoid clinical negligence in the future, which would obviously address that in the future.

Ms Daly: Absolutely, staffing is an issue in the elective care waiting lists, and that is something that we need to look at when considering recruitment practices and how to bring staff into some of the areas in which it is more difficult to recruit. There are a number of issues that contribute to this situation. As was said earlier, one of the things that we need to look at is the improved management of referrals in primary and secondary care to ensure that only those who should be referred are referred. There are other issues that go into some of the other things that we talked about, such as looking at productivity and improved productivity within the trust. As I said, there are times when beds can be reduced. That in itself is not a bad thing, so long as we can set that in a context in which things are being done in a better way.

There is, of course, the reconfiguration of services. Again, that is something that is being considered in the whole transformation — without doubt, increased funding to increase the acute capacity. So, there is a range of things. Looking for this funding is absolutely necessary, but, along with that, we have to ensure that all the other programmes of action are being taken forward together.

Mr Dunne: Thank you very much for coming in today. Some of my questions have already been asked. The summary table on page 32 shows £5·1 million for other specialties. What does that include?

Ms Daly: There is a range of other specialties. That table highlights the key specialties in which there are pressures, but there is a range of other specialties. Some of those are the smaller specialties. I am trying to find that information here.

Ms Thompson: Cardiology and oral surgery are part of it. I guess that it is an amalgam of a range of specialties. The bigger specialties have been listed separately, so it is a range of smaller specialties.

Ms Daly: I do have the information.

Mr Dunne: Do not worry.

We are aware that people are waiting quite a long time for plastic surgery. Will this go some way to address that?

Ms Daly: Absolutely. Again, this is addressed at waiting lists across all those specialties. The intention is to ensure that services are delivered within the Minister's agreed targets for waiting. Absolutely; across all those specialties that should ensure that people are seen quicker.

Mr Dunne: Should we see improved efficiency as a result of that additional funding?

Ms Thompson: You will see another 220 outpatients on plastic surgery and a further 1,100 inpatient and day cases at a cost of £2·2 million. That will certainly help to address the waiting lists in those areas.

Mr Dunne: Transforming Your Care has gone a bit quiet with us recently. What about the role of GPs and their interaction with the community and, as a result, a reduction in the workload for A&Es? How is that being worked out?

Ms Daly: That is continuing under the transformation programme. The oversight committees for all 17 integrated care partnerships (ICPs) have been established across Northern Ireland. They are operating and have met on a number of occasions. Membership issues to do with the integrated care partnership and wide collaboration are being addressed. The establishment of the ICPs, which is fundamental to this process —

Mr Dunne: How is that funded?

Ms Thompson: We received £9·4 million in the June monitoring round. Of that, £4·5 million was invested in ICPs. That money was, effectively, received in June monitoring, hence we do not need to bid again for it.

Mr Dunne: OK, so it is in there?

Ms Thompson: Yes.

Mr Dunne: Right, that's grand.

Mickey covered the point about stroke services and the five service professionals. Do we need those as against having teams of professionals, doctors and specialists? We go back to the old thing about whether we need all those managers in the health service. How do you justify that?

Ms Daly: That is about looking at new care pathways and ensuring speed of flow to get the person to the right place with the proper care as quickly as possible. Those staff are in place to ensure that, right from the occurrence of stroke, patients are directed to the correct place to get immediate care as quickly as possible. They are developing the care and care pathways around that stroke process, which is a fundamental part of the work that the ICPs will be looking at — those early areas that have been identified, such as the frail elderly and stroke services.

Mr Dunne: Some £20 million will now be taken out of our care package to address the issue of negligence. What is being done internally to look at processes to try to manage the risk and reduce the likelihood of recurrence of such issues?

Ms Thompson: You are absolutely right: the reason for the bid is obviously to avoid an impact on the health and social care budget by bidding into the central DFP process. There is a range of initiatives to minimise that issue. We have 'Quality 2020' in place as part of a strategy to improve the quality of services. There is a big focus in trusts, as Catherine said, not only in their performance but in the safety and quality of services. We have serious adverse incident reporting, lessons learned and the sharing of those lessons.

There was considerable focus on that in the Public Accounts Committee (PAC) last year. We are working through the recommendations within that as well. A lot of that is focussed on not waiting for the clinical negligence end of the process but making sure that the lessons are being learned right up front and that all the lessons learned are applied right across the piece to avoid it happening again. Medicine can be an inherently risky business, and, therefore, we need to ensure that any lessons learned are appropriately shared and that people are managing those and learning from them as best as possible. There is a whole range of initiatives in place to enable that to happen, but it would be wrong to say to the Committee that clinical negligence will not be there in the future. Unfortunately, there will always be an element of that as we look forward.

Mr Dunne: So, are you satisfied that managers are doing what they can to manage the risk internally and reporting accordingly?

Ms Thompson: The primacy is within the trusts that things are reported through. One of the issues at the PAC was around how you know whether people are fully reporting the extent of what has happened, and what has been done around that is about encouragement, as far as possible, to create the right culture so that people feel content to do so. That is one of the aspects moving forward. As I said, you will never be able to eradicate it, but we need to try to minimise it as far as possible.

Mr Dunne: OK. This is just negligence of health professionals. It is nothing to do with accidents at work.

Ms Thompson: No. This is the treating of patients.

Mr Dunne: OK. Thanks very much.

Mr Beggs: You have indicated that there is considerable pressure on the system at the moment and waiting lists are lengthening. Are any waiting lists shortening?

Ms Daly: Yes. There have been improvements. Going back to March 2012, there had been significant improvement across a number of waiting lists over that period. There has been some deterioration in those since March. There are areas where there have been improvements, and I will pick up on some of those. I pick these at random, but, for example, there has been improvement in cancer care and the 62-day target. We are absolutely clear that that target is not being met, but the length of time taken for treatment is significantly reduced. The 62 days remains the standard to be addressed, but we know from the board working with the trusts that, in most trusts, no patient waits longer than 85 days, and that is pushing to the 62. That is slightly different for the Belfast Trust, where it is 95, and that is because of the transfers, but this is an area of significant focus.

An important one to mention is A&E. We know that the four-hour target is nowhere near being reached. There has been a slight improvement, but it is nowhere near the standard. That is a key focus of our accountability meetings with the board and the board's engagement with the health and social care trusts. On the 12-hour target, we have seen significant improvement. I do not have the individual figures for the Northern Trust, but the reduction there has been considerable. In July, they had 15 breaches, which were due to a surge that could not have been forecast. So, that is another area where there is improvement, but I have to emphasise — this is where the Minister's clear focus is — that improvement needs to happen, but it needs to happen to the targets. Where there is improvement, that, in itself, is not sufficient; it needs to be in line with the ministerial targets.

Mr Beggs: In your elective care bids, there is £4·3 million for orthopaedics. In paragraph 9 of that subsection, you have indicated that trauma and orthopaedics continues to have a significant capacity gap. I assume that trauma is when there has been an accident or something of a very urgent nature. Are you telling us that significant delays are happening? In the past, friends of mine had to wait at one hospital before they even got a bed, and it was a week before they got to an orthopaedic hospital. Is that type of thing happening again?

Ms Thompson: The trauma and orthopaedics heading is simply the full name of the specialty in its entirety. The bid is focused on the elective element of orthopaedics.

Mr Beggs: OK; so that is not the emergency.

My other question concerns ophthalmology. There is a bid for £2·6 million for that. It strikes me that some of these bids happen every year. Has the Department taken a longer-term look at where it has regularly had to put in extra money, so that we can get better value for money? It has been said to me that relying on in-year monitoring every year is a bit of crisis management, and you do not necessarily get the best value for money by going, over the short term, to the private sector. Perhaps we should be looking at where we are with our baseline services, rather than, every year, committing several million pounds to one particular service. You know that you will do the same next year. What assessment has been carried out on that?

Ms Daly: As I said, part of that is a real increase in the demand, and we have a recurring capacity gap there. Under ophthalmology, the gap is for nearly 4,000 outpatients and nearly 700 inpatients. That is a resource gap in the whole system. You are absolutely right: we can muddle through in moving from one monitoring period to another to try to get this funding. If we do not get this, there will be longer

waits. That is absolutely clear. However, part of the whole programme of moving forward is to look at better ways of delivering services.

When the transformation takes place under TYC and we have a more optimum and proper spread of resources, some of the pressure will be taken off hospitals, which will allow more time to deal with the demand that they face. It is not something that we can give you an answer to now, but it is an area that is part of that whole strategic focus.

Ms Thompson: To provide further assurance to the Committee, I can say that a demand and capacity analysis has been done for every specialty, working out where demand is going and what capacity exists in the trusts and identifying the gaps. A programme is then put in place to, if you like, increase the HSC investment. So, alongside the work that is ongoing through the monitoring rounds, there is ongoing investment within the HSC baselines; but it cannot all be done at once. Hence, the bids are made to support that as it moves forward. You are absolutely right: the programme and the strategy around that is worked out in depth, and where there are gaps, they are plugged on an ongoing basis; they just cannot all be done at once.

Mr Gardiner: In your list, separate figures are quoted for gynaecology, pain management and plastic surgery, but you have £5·1 million for "other specialties". What are they?

Ms Daly: That was what I was looking for earlier. I thought that I had a list of them. I do not have the details. We will bring that list to the Committee, because I appreciate that that is a significant amount.

Mr Gardiner: It is the largest on your list —

Ms Daly: Yes, I —

Mr Gardiner: — and you do not know what it is for.

Ms Daly: I just do not have the breakdown. In putting the bid together, we have the information that goes behind that. I do not have the list with me, but we can provide that to the Committee.

Ms Thompson: An element is for cardiology and for oral surgery, and it is then made up of a range of other smaller specialties. So an amalgam of much smaller elements make up that total of £5·1 million. We can certainly provide that to the Committee.

The Chairperson: OK; thank you. I know that you are staying for the second evidence presentation, but I want to say something that, I think, is important. I am conscious that something in the region of £9·4 million was received in the previous monitoring round, and, obviously, this bid is for £64 million. Despite being the optimist, I do not think that that target will be reached. The Department must have priorities when it comes to bidding, particularly for monitoring rounds. It would be useful — this is similar to Sam's point — for us to have those priorities, so that Committee members can reflect on how we view them. There will be a pecking order to a lot of this stuff, and I suggest that you share that with the Committee.

Ms Thompson: The process is led by DFP. You are quite right: the Executive will take a view on how much will be financed, whether an element of finance will be provided for each of those bids or whether, for example, only one is successful in totality or otherwise. That process will be ongoing. There will then, potentially, be discussions with the Minister about where he views the priorities, depending on the outcome. It really does depend on where other Departments are with resources, and the assessment of the overall financial position at DFP level. You are quite right: it is a significant bid.

There is one more opportunity to bid, which is in January, if we are not successful now. However, we would really welcome having more clarity now going into the winter. It is complex and, to a certain extent, the Executive will decide what they will give us.

The Chairperson: I accept that. I also accept that there is a process, but I suggest that the Department has a list of priorities. If you are bidding for anything, you know your top four priorities; they must be there. I suggest that they are shared so that we can have a collective understanding of the top two or three priorities.

Ms Daly: The bids going forward reflect that they are priorities for the Department. For example, clinical needs would be an inescapable cost, which, when you do not have that funding in the budget, by their nature need to be prioritised because they will be required to be funded. A process is then undertaken in the Department to identify pressures. As Julie said, we are restricted in our participation in the monitoring round, but the bids do reflect priorities for the Department.

The Chairperson: I am going to lobby on this point a bit more. I accept that you have had the discussion around major and unforeseen circumstances. We also had the discussion that issues such as waiting lists are not exactly unforeseen when they have been going on for quite a number of years. I accept that there is cross-departmental and Executive buy-in into this but, ultimately, it must come back to a pecking order somewhere in the Department that says, "If money becomes available, here is what we would like to bid for." I am requesting that that information is shared with us.

Ms Thompson: I am certainly content to do so, albeit I emphasis again that the Executive will determine ultimately where those priorities lie. However, as to going back and saying which of those three bids are the more important, it is for the Minister to consider before coming back to the Committee.

The Chairperson: OK, but you will come back to us to share that information with those caveats.

Ms Thompson: Yes.

The Chairperson: OK, thank you for that.