Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Waiting Times: DHSSPS and Health and Social Care Board

4 June 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Waiting Times: DHSSPS and Health and Social Care Board

4 June 2014

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

Witnesses:

Dr Eugene Mooney	Department of Health, Social Services and Public Safety
Ms Heather Stevens	Department of Health, Social Services and Public Safety
Mr Chris Stewart	Department of Health, Social Services and Public Safety
Mr Dean Sullivan	Health and Social Care Board

The Chairperson: You are very welcome, folks. We have with us, in no particular order, Heather Stevens, director of service delivery at the Department; Mr Chris Stewart, director of healthcare transformation at the Department; Dr Eugene Mooney, director of information and analysis at the Department; and Mr Dean Sullivan, director of commissioning at the Health and Social Care Board (HSCB).

I advise the witnesses that, in the process of our inquiry, there are a number of key issues that the Committee wishes to discuss today. We want to work through each of these in turn and use the opportunity to gain an understanding of the position of the Department and the board on these issues before we make any recommendations in our report. We would welcome an open and constructive debate. You know the formalities, and I understand that you will make an opening comment.

Ms Heather Stevens (Department of Health, Social Services and Public Safety): Thank you very much, Chair. We are grateful for this opportunity to participate in the Committee's review of waiting times and build on the input that the Department provided to the Committee back in January and February. We appreciate that you have set out a number of areas that you want to explore with us, so I will be very brief in these opening remarks.

The need to improve access to health services and, in particular, to reduce waiting times is certainly a key priority for the Minister. It has been pursued through setting standards and targets in successive commissioning plan directions. However, we in the Department fully accept that, in many instances, performance is not where it should be, although some progress has been made compared to the

position of, say, eight to 10 years ago. We also know that this is one of the most complex and challenging issues that we have to get to grips with. That has, in fact, been a message that has come through consistently in these evidence sessions.

It is a universal problem, and no one seems to have identified the magic bullet to fix it. Instead, we can see that different countries are approaching it in different ways. We are very keen to consider practices and learning experiences from other countries or regions that have implemented different models to reduce elective waiting times. We very much welcome the Committee's thorough investigation of these issues. We look forward to receiving your recommendations in due course. We would welcome sight of any further evidence that is available on the efficiency and effectiveness of other approaches as we continue to seek to improve the patient care pathway and experience.

We know that one such approach is to look at measuring the entire patient journey through a referral-to-treatment time. This approach is being followed in a number of countries — England and Denmark, for example — but the key thing is that it is early days in their implementation of that approach. We are very keen to learn from that and look at the experience elsewhere in order to inform whether the significant investment needed to pursue this approach in Northern Ireland is worthwhile, particularly in the prevailing financial climate that we find ourselves in. However, while we assess the merits of other approaches, our immediate focus continues to be on improving the waiting times for the individual elements of the patient pathway, namely outpatient assessment, diagnostic tests and inpatient day case treatments.

We are in the process of developing, in parallel, other measures that are much more focused on the outcomes and experiences of the patient to help them make informed choices and help address the issue, which was identified by Professor Normand in his evidence, that a lengthy waiting time may not necessarily mean that a patient is suffering a detriment.

We also know that reducing waiting times is not fixed by simply focusing on elective care provision. There are important linkages between other parts of the secondary care system — for example, unscheduled care — as well as primary care. So, a whole system solution is required that looks at patient flow right across the piece.

We have robust information. The HSCB has carried out a demand capacity analysis across all the secondary care specialties so that the board knows when demand exceeds the capacity of the trust to deliver. However, we also know, and the evidence sessions have again borne this out, that what is needed is not simply a supply side solution with additional capacity being brought in to reduce ever-growing waiting lists. We need to find ways to manage demand in the context of a demography that can present only an unsustainable increase in demand. So, local commissioning groups (LCGs) are already working on developing pathways to reduce pressure on secondary care services. We are, indeed, starting to see some exciting new initiatives from GPs themselves in the form of federations or clusters of practices maximising their own particular interests and areas of expertise in order to reduce referral rates.

In summary, we know that we have a significant challenge to grapple with and that we have to tackle it in a number of ways. We have to manage demand but also continue to invest in capacity and make sure that we measure progress effectively, all while making sure that we keep the needs of the patient absolutely at the front and centre of this. Chair, that is all that I want to say by way of preamble. Colleagues and I are happy to go through the issues that you have raised and answer any questions.

The Chairperson: Thank you for that, Heather. I am initially seeking your view on the referral-to-treatment time. One of the pieces of information that we discovered as we have gone through the inquiry is that, if there are only the stage-of-treatment targets, there can be perverse incentives for managers to delay patients. Do you have a view on that or a sense of it?

Mr Chris Stewart (Department of Health, Social Services and Public Safety): Chair, if it meets with your approval, I will answer that and, in doing so, expand a wee bit on some of the things that Heather said. First, to answer your specific question, we recognise the potential in the system for those sorts of perverse incentives.

I am not aware — unless Dean is aware of anything different — of specific evidence of that happening in our system in Northern Ireland. Nevertheless, we recognise that the potential for it would be there. In overall terms, it is important to emphasise that the Department's view on a referral-to-treatment target is that we think that it is highly desirable for the range of reasons that have been given to the Committee in recent weeks by the other witnesses who have come before you, because it would

remove those perverse incentives and take them out of the picture completely, it would better reflect patient experience and what the patient is really interested in, which is the entire journey, and we think that it would also reflect the clinical interests. Doctors and other clinicians are interested in the patient's entire experience. Therefore, we would have a much better target all round as and when we were ready to move to that.

It would also ensure that we have a complete end-to-end focus on performance and we would be able to ensure that any hidden delays in the system were being identified and tackled. Therefore, for all those reasons, we think that a referral-to-treatment target would be a very good thing.

As you have heard from a number of witnesses in recent months, it is difficult to achieve, and there will be a number of challenges that we will have to overcome in moving to that form of target. They fall into three broad groups: policy, resource and technical feasibility. I should stress that those are not excuses for not doing it, and we think that all of those are capable of being overcome.

With regard to policy, there are a number of key decisions that we would have to take. First, how would we do it? As Heather said, this is still a relatively new approach. It is not particularly well established around the world and there is no single obvious best practice model that we could pick at the moment to follow. That does not mean that we cannot do it; it just means that we have a difficult choice to make up front.

We also need to look at some more technical aspects of policy. What type of measure would we adopt? Again, you have heard from witnesses in recent months that there are several approaches that you could take to this. You could have a snapshot of those who are waiting within the system at any given time, or you could base a measure on completed journeys, and there are advantages and disadvantages to both. You could measure completed journeys, where you know exactly what the experience has been for those patients and where the problems have been — if there have been any — but that measure is retrospective. It tells you what the system has done, not what the system is doing or is going to do. A snapshot of people waiting is more current but is not complete: because people are waiting and you have not entirely bottomed out what their experience has been. Therefore, there is a choice to be made. What type of measure or, perhaps, would both need to be included?

Another key issue in policy terms at the system level is that if we are going to use such a measure, not just to manage the performance of our own system day to day, week to week, month to month, but also to do a comparative analysis of how we are doing against other jurisdictions — I am not saying that we have to adopt the same measure as every jurisdiction — we have to have a rich understanding of what the differences are so that we can make some comparisons.

The second group of challenges relates to resources. Again, you have heard from witnesses that this is not something that is easy or quick to do. It would take a number of years of hard work to get it in place, with perhaps investment running into millions of pounds to put it in place. Of course, there is an opportunity cost there. Undoubtedly, it is a very good thing to do, but while we were doing it, we would have to divert some of our performance management resource to develop that new approach, so there is a danger that our eye might be off the ball with regard to managing the system while we develop the new target.

Related to that, we have heard from the Scottish and English experiences that those developments and the introduction of those targets need to be preceded by a focus on getting the performance and the measurement right in the individual stage targets that we have. So, there is a challenge for us in trying to do both of those things at once.

The third set of challenges is around technical feasibility. We need to be certain that the information systems that we currently have are compatible with that sort of approach, that they are comprehensive so that we are capturing all of the elements of a patient's journey, and some development of systems would be needed. We need to think carefully about how we do that. To put it candidly, do we rip out and replace the existing systems or do we try to overlay them with a new system that would sit on top and gradually replace the legacy systems underneath? There is a key decision to be made there.

Chair, I am afraid that you and the members will know of many examples in the public sector where the approach has been based on "rip out and replace", and we have not got it right. Information projects have gone over time and over budget. I think that there is a strong argument for trying to overlay a system on the existing systems and replace as they come to the end of their natural life. A very good example of that is the electronic care record. That was the approach that was taken: we did not rip out and replace. The existing systems will reach the end of their natural lives and be

replaced, and each time that happens they will be compatible with the overlying electronic care record system.

All those challenges have to be overcome, and there is one final point that is worth making. When is the right time to introduce a referral-to-treatment target? There is a strong argument for saying that the right time and the right context would be as part of a change to commissioning arrangements. We do not commission full patient journeys let alone outcomes. However, we commission episodes or stages of treatment. Success in that approach is much more likely if we can get those two things aligned. If we can move to new commissioning arrangements so that we are commissioning patient journeys, better still outcomes, and so that the currency that we use, both for commissioning and the measurement of performance is the same.

We do not offer those to you as a series of excuses for inaction but simply as a candid description of the things that we will need to do to put this sort of target in place.

The Chairperson: Thank you for that, Chris. I welcome the detailed response. Can I take it that when you say that referral-to-treatment, as a system and process, is highly desirable that the Department is committed to it in principle at least?

Mr Stewart: That would be a policy decision for the Minister, but, in replying to the Committee, the Minister has endorsed the line that it is highly desirable. He will expect us to treat that as a priority.

The Chairperson: That is ultimately a shift — a welcome shift, but a shift nonetheless — from the engagements that we had before on the issue.

Mr Stewart: It is a shift in the sense that it represents the leading edge of best practice. As we have said, it is not practice that is fully developed; we are watching developments in other places. Nevertheless, it is the direction of travel for those who at the leading edge. If we want Northern Ireland to be at the leading edge, that is the direction in which we will have to go. It is highly desirable, but, as I said, and this is not a cop-out, policy decisions are for the Minister rather than us. But, it is recognised that that is best practice.

The Chairperson: In the response that we had from the Department, there was talk about a move to referral-to-treatment (RTT) measurement being challenging both financially and logistically. You outlined that in your comments around policy, resourcing and technical feasibility and gave us some details on that. Are we about to move to a business case? Has there been consideration of feasibility and cost?

Mr Stewart: No, we are not at that point. I would be misleading the Committee if I gave you the impression that we were about to go to that point. A great deal of work would have to be done first.

The Chairperson: OK, but we are moving in the direction of considering —

Mr Stewart: As Heather said, we recognise that that is best practice, but we recognise that the Committee is doing an important and serious examination of the area. We would want to see your recommendations and conclusions before putting definitive advice to the Minister.

Ms Stevens: As we said earlier, because the other countries have gone down this route at an early stage, we want to monitor how they are progressing and learn from their mistakes and the good practice that they identify.

The Chairperson: So, are there engagements from the Department with other countries and regions?

Ms Stevens: We are at the start of that engagement. The review that the Committee has undertaken has been enormously helpful in identifying where we can usefully look.

The Chairperson: OK, glad to be of help.

Mr Dean Sullivan (Health and Social Care Board): It is not totally new to us in Northern Ireland: we have one pathway where we measure from referral through to treatment for cancer patients. So, for patients referred urgently by their GP, there is a 62-day target that the Minister has set, whereby 94%

of patients are required to commence their treatment within that 62-day period. So, that demonstrates for us all that it is feasible in principle, but I fully agree with my departmental colleagues about the technical and logistical challenges that there would be around a big-bang approach to introducing that more generally. The cancer pathway shows that there might be a possibility, subject to the view of the Minister and others, of incrementally moving towards that.

The more fundamental issue is around making sure that at least the individual stages of the pathway were broadly in the right sort of place before moving to that system, otherwise you would just be measuring differently something that was not what you wished it to be. Moving to total patient journey time measurement would not in itself fix underlying major difficulties at any individual point.

The Chairperson: I think that some of that will come out in the discussion around targets in general and their enforcement.

Mr Beggs: How long has the cancer treatment system been running and what has been your experience of it.

Mr Sullivan: Mr Beggs, as I recall, the 62-day cancer target was introduced in 2007.

Mr Beggs: I am interested in your monitoring systems.

Mr Sullivan: The facility was in place to monitor that target in the 2007-08 financial year, as I recall. I am sure that departmental colleagues can check that and confirm that to Committee members after the meeting. That was the target at the time in England and an equivalent target was introduced in Northern Ireland. I understand that England has now reduced that to 85% rather than 95%. Therefore, for cancer, that has been in place for several years.

Mr Beggs: Why could that software system not be extended to other departments?

Mr Sullivan: Chris can speak for himself. It is less the software technicalities around some of all this; it is the sheer scale of things. You are tracking for the patients who are urgently referred with cancer and who go on to require definitive treatment. It is a tiny subsection of the numbers that we are talking about here in terms of the breadth of specialties, trusts, systems and so on. All of that could be teased out. The more fundamental issue for me is around getting everything ready for the system to be introduced rather than necessarily huge systems — issues that Chris talked about —

Mr Beggs: Why can it not be rolled out? It does not have to be a big bang. Why can it not simply be adopted in another department, for instance, and widened?

Mr Sullivan: The scale of things within cancer, where you are talking about patients in relatively small numbers each month, allows a different and more targeted approach than something in relation to elective care more generally, where we know we would be talking about tens and hundreds of thousands of patients, as opposed to dozens and hundreds of patients. It is simply a scale thing.

However, you are right; the principles would not necessarily be any different. We are able to identify when an urgent referral has been made, and we are able to identify all the bits in the pathway, including the complexities in cancer patients perhaps being seen in the first instance in, say, Antrim, and then if they require specialist care like radiotherapy, the patient would then be referred into Belfast. We are able to track the patient around the system in that way, but it is because the numbers of patients are literally slightly more than handfuls but not in thousands that we are talking about. However, I am sure that you are right; the principles would be applicable.

Mr Stewart: Just to add to that, I think that it is an issue of scale. Once we reach the point where there is a software system in place, it can pull out all of the various pieces of information and stitch them together. Yes, you can roll that out anywhere. I do not know, but I suspect that there is an element of manual processing in the cancer target at the moment. Again, as you heard from the Scottish experience, that is one way of starting, which is that you can have a largely manually driven process and have people with the role of patient trackers joining up the various pieces of information at the minute. It is hugely labour intensive and it would be a distraction of resources from, as Dean said, managing the bits of the system that we know are not working well enough at the moment and where the real problems are. It could be done that way. However, it is not a terribly efficient way of

doing it and probably not a terribly effective way of doing it. At the sort of scale where you would be rolling out to the big numbers in, say, orthopaedics, it is probably not practical at the moment.

Mr Beggs: Can you tell us something more about the current patient administration system? How old is it and what is its life expectancy?

Mr Stewart: I have to look to my colleagues for that. It is not something that I have detailed knowledge of personally.

Dr Eugene Mooney (Department of Health, Social Services and Public Safety): I could not say in terms of years, but I know that it has been raised by the Committee in the past. When we looked at consultant cancelled outpatient appointments, we looked to see whether it could be revised. However, the patient administration system is common across the UK. It is not a question that it is not fit for purpose; it is fit for the purpose for which it was designed. With regard to introducing a referral-to-treatment target, there are a number of stages where we switch clocks on and off. My colleagues have talked about where some of those clocks start and stop. There are parts that we miss; we miss when the decision is made to send a patient for a diagnostic test. It will stop in terms of the time taken to report that back, come back to the consultant, the consultant to look at that and make a decision and then have a review appointment.

Mr Beggs: Why does the clock stop?

Dr Mooney: It is just because there are different systems in place to record. We have different systems for inpatients, for outpatients and for diagnostics. One of the things that we are seriously looking at is if we have captured a number of the elements of the stages, and as we are now looking at the clinical community gateway, we are looking to see if we can get most of the referrals that are coming from GPs through electronically. So, we will know that they are all coming to the trust, and we will be able to capture how many are coming through there, and then at the other end of the stage. So we may still be able to get that time difference, but maybe not in the way that our colleagues across the UK have it.

Mr Beggs: To go back to my question, how old is the current system?

Dr Mooney: I do not know the exact date.

Mr Beggs: Can you come back to us with that?

Dr Mooney: I certainly will.

Mr Beggs: I recall that when we were looking at missed appointments, there were difficulties in adopting new technology, such as automatic text messaging and that sort of thing. What is the cost of those missed appointments? Do you accept that a new system might bring about a number of other benefits, as well as capturing the referral time to treatment?

Mr Stewart: I think that there is no doubt that investment in improving the systems will bring all sorts of benefits such as those that you have described. I am afraid that we will have to come to you with the detail on the PAS system, as none of us are familiar with that. In respect of a strategy to achieve that, I will go back to what I said earlier: the first decision that we face is, do we rip out and replace, or do we adopt what instinctively what would be the better approach, which is to look at things such as PAS and look at its limitations and where it is falling down, what is its natural life cycle and how close is it to that? In replacing it, underneath some sort of a portal or overlying system that would sit on top of that to ensure that its replacement has those features that you have talked about, such as automatic text messaging, which simply would not have been thought of when PAS was introduced, I would imagine, because that sort of technology did not exist. It is the very opposite of a Big Bang approach. It is graduated and it is incremental, which means that you do not realise all the benefits for some years, but it is lower risk, and as we have shown with the ECR success story, ultimately, it is more likely to be successful.

Mr Beggs: From talking to your English colleagues who have the system, do you have a ballpark figure of what it would cost here?

Mr Stewart: I am not aware that there is a reliable estimate for Northern Ireland.

Mr Beggs: Have you seriously looked at it, if you do not have a figure? Do you even have a guesstimate?

Mr Stewart: No, is the straightforward answer to that. I do not think that there has been an estimate made.

Mr Sullivan: Chair, if it is helpful, Mr Beggs referred to the issue of patients not attending appointments on the day of the appointment or cancelling on the day of the appointment. Having sat with a different hat on in front of this Committee and other Committees in the Assembly, I know that if we had been here three or four years ago, the typical DNA rate was around 11% or 12% against an English average at the time of about 10·5%, as I recall. The position in Northern Ireland now is materially different to that. The position last year in Northern Ireland was that about 7·5% of patients did not turn up for their appointment on the day. That is lower than the equivalent position for England. So there are always further opportunities, ideally through technology, but through other measures as well. I do not think that would be the only reason why you would introduce this, and I know that you are not suggesting that. I think it is important for the Committee to be aware of the demonstrable progress that has been made in relation to that issue, which has been an important issue for this Committee and other Committees in the Assembly.

Mr Beggs: Another issue that I hope you will accept is that people who are partially sighted have been unable to get appropriate messages through a variety of means because of their disability, if you like, and the technology in our dated systems. Do you accept that a number of other benefits would follow?

Mr Sullivan: I think that would be a very important spin-off benefit, yes.

Mr McCarthy: Thanks very much for your presentation. I want to talk about enforcement of targets and the tools that you have to ensure that the targets are met. You have issued us with some correspondence, but there are a few other questions that I would like an answer to. Is the monitoring of targets for waiting times for elective care completely delegated from the Department to the board? Who leads on that area of work in the board? Do they have the expertise and resources, in terms of time and staff, to effectively keep on top of what the five trusts are doing? Does the approach of a financial punishment of trusts who do not meet their core activity work? Who is actually impacted by it? I notice from your correspondence that the board withdrew some £876,000 from three trusts in 2013-14 for not delivering against core activity. That was a punishment but, at the end of the day, who is at the end of that punishment? It must surely be the patient. Is it?

Ms Stevens: Dean, do you want to start with the board's role, and I will come in and say what the Department does?

Mr Sullivan: I am happy to proceed on that basis. Go back to the legislation: the 2009 Act makes it clear that the board is responsible for performance management and service improvement to ensure the delivery of ministerial standards and targets, of which elective care are clearly some. Who leads within the board at director level? We have a director of performance who is a colleague of mine, Michael Bloomfield. He and I work very closely together, obviously, with the commissioning and the performance bits being two sides of the same coin, and we also work very closely with our finance colleagues. Do we have the necessary skills to do that? Certainly, within the board, we have access to a range of different skills. Michael and I have been directly involved with this for about 10 years previously in the Department. We have, through the work that we did in the Department and more recently, secured, at points in time, substantial improvements in waiting times. What we are talking about today is how, in a very resource-constrained environment, with the demographic increases and pressures that Heather has referred to, secure sustainably short waiting times? That is where we are keen to focus.

To answer your other question — do we have the necessary tools? — I will remind Committee members of what we actually do. The most important tool, perhaps, is timely, robust information. We certainly have that; we had that in departmental days, and we now have it in the board for the past seven years or so, so we know on a weekly basis what the numbers look like by organisation and so on. With the agreement of the Department and the Minister, last year we introduced the sanctions to which you referred, whereby, if a trust materially underperforms against its agreed contract, then the

funding is withdrawn at a marginal rate. That is what has happened, and that should not directly impact in the short term on any patient; it is more to encourage the right sorts of behaviours in the system. Clearly, at scale and over time, there would be the risk, in Northern Ireland terms, of an outcome in that regard, but it is trying to avoid the sanction being applied at all, Mr McCarthy.

Beyond that, it comes back to what Heather talked about, which is the correct place for us to go. All the discussion to date has been about what we can do at scale in primary care to manage demand differently, and there have been very active discussions with very senior members of primary care, involving colleagues sitting beside me and myself. One initiative in that regard at scale is due to commence during the summer, in addition to a number of other smaller-scale initiatives in terms of better management of the demand at source in primary care. Equally, though, within trusts, we are trying to move away from what is quite an operational, transactional arrangement with trusts at the minute. As we speak, Michael is meeting with two of the trusts this afternoon as part of a series of fortnightly meetings that we have with trusts toward having a less hands-on, less transactional, less operational arrangement, whereby trusts and clinicians are empowered with — as Chris touched on — a greater focus on outcomes. One of the key elements of that, not just actual patient outcomes, is obviously timely access to care which, in some cases, is a key prerequisite to a satisfactory outcome. So we are looking at the fundamentals of that and how we might reform things going into the future.

Ms Stevens: Shall I add the Department's role in that? It is twofold, really. First, the board itself is an arm's-length body of the Department, and we meet monthly with Dean and Michael. A report is produced on performance right across the commissioning plan standards and targets, and we go through that in some detail looking at individual trusts, where the areas of good performance are, where best practice can be identified and shared, and where performance is falling short — and the reasons for that and what the board is doing about it to help trusts to improve. That is one approach.

Secondly, the trusts are also arm's-length bodies of the Department, and there is a very formal accountability and assurance process in place whereby, twice a year — mid-year and end year — the trusts are brought in, and a meeting is held with the chair, the chief executive and senior members of the trust's management team. It is chaired by our permanent secretary. We formally hold them to account on a range of issues, such as a raft of corporate governance issues flowing from their governance statement. We look at their performance on targets generally; we look at their performance on finance; and we look at their performance on quality and safety. The board is invited to those meetings to give its assessment of performance, and the trust is then given the opportunity to come back and give its report to the Department on the reasons behind any areas of underperformance.

That process is particularly significant this year, following a letter to all of the trusts from the permanent secretary back in November. That letter set out our commitment in the Department to do a strategic assessment of the trusts' position on quality, finance and performance. That will be completed when we do this round of end-year assurance and accountability meetings. In fact, that letter from the permanent secretary held out the possibility of further intervention on foot of that process, and escalation is a possibility, if required.

Mr McCarthy: To finish, Chair, that £876,000 that was taken off the trusts concerns me. In England, for instance, they use a "targets-and-terror" approach. Do you know what is coming? Chief executives lost their jobs. That is putting on them the blame or the responsibility for not delivering what was expected of them, rather than taking cash from the trust, which, obviously, will come down to the patients. That has not happened here; at least, I have not heard about it. Is it likely to happen in the near future? In Portugal, they offer incentives. Only doctors who have met their basic targets are permitted to do additional in-house work. Is there anything like that on your radar?

Mr Sullivan: I will go back to how it manifests itself. We withdraw funding for services not delivered at 25%. In reality, that 25% is largely related to consumables, and so on, associated with that activity and might have been incurred anyway. So, at the minute, I am fairly certain that there is not a material impact on other patients within that LCG or trust area. The total figure for the Committee to be aware of in the three quarters in 2013-14, which supersedes the information that you have, is £1·5 million being withdrawn for under-delivery. Departmental colleagues will have a view. I do not think that it is helpful for all of us to get into some sort of blame culture. It is about trying to create a system where, in particular, clinicians in primary care and secondary care are facilitated to do the right things for patients and in which, hopefully, we can avoid sanctions, threats, terror and any other unpleasantness.

This is all much more straightforward for all of us, particularly the patients, if they receive timely access to care. I am confident that that is the direction that the Minister and the Department are continuing to work towards. I can speak on behalf of the board, and it is certainly the direction that we are seeking to work towards. That does not mean that, from time to time, as is the case currently, we will not face particular challenges. I encourage members to look at the movement in these numbers over time and be assured that, between the Department and the board, we will turn this around. There are challenges with that, and we have talked about some of those, but I think that we have the building blocks to allow that to be turned around. However, because it is of such a scale, the difficulty is that it is not just a quick flick of a switch so to do.

Mr McCarthy: To finish, Chair, until we see real efforts to get on top of this, it is going to continue. If you come back here this time next year, will we be seeing the same problem?

Mr Sullivan: I can assure members that, from the board's perspective, real efforts are being made every day of every week in looking at this as a specific agenda issue. This is not something that we come round to once a month; it is something on which there is an acute focus within the board and trusts — probably, bluntly, too much of a focus on it, because there are bigger prizes around Transforming Your Care that we need to be focusing on, and almost making this part of routine business. Clearly, the two are not unconnected. The demand management initiatives within primary care, particularly, and the discussions with leaders in that regard, are entirely consistent with the Minister's vision as set out in TYC. But that is where we need to be focusing, and the other being just more routine business.

The Chairperson: It is important that there is a role for the Committee in understanding the Department and the board's view or policy on a specific way forward. Kieran's question was around those kind of financial almost punishments and their use. Did they achieve anything? What I am hearing from you is almost a sense that we do not want to move to that blame culture. If we are saying that, are we then saying that we will look at a process of incentives? And if we look at incentives, what will they be?

Mr Sullivan: I commission services. If any of us in our day lives are going to Tesco's, we are not spending money for things that we do not receive, so I reserve the right — and I think you would expect me, working on your behalf, to have a position that if routinely services were not delivered in the required volume or to the required standard, there would be some comeback to the relevant provider. That seems entirely reasonable and does not sound to me like a sanction or anything. That is just routine commissioning from a provider organisation.

I was trying to explain my desire and the board's desire not to get to a place where every problem becomes an opportunity for everyone to point fingers at everybody else in the system. I would rather that our collective efforts were spent on trying to fix the thing, so if I was unclear in responding to Mr McCarthy, I apologise. I was simply trying to say that we are at a place that we are at. We are trying to avoid any blame culture. I do not think where we are now is, and I saw the quote, in terms of the "threat and terror" from across the water. They have been in a slightly different position from us in that regard, but they are a different system and on a different scale from us.

The Chairperson: Specifically, Dean, because I know there are a number of people who want in on this particular issue: the incentives culture.

Mr Sullivan: On the incentives culture, I touched on the board having progressed discussions with a small number of provider organisations within Northern Ireland in recent months around a small number of specialties. That has been a much more open-ended discussion, which is whether we can move away from a transaction-based approach whereby my relationship with you as a provider is to buy three of these, four of these and five of these, to an arrangement whereby my relationship with you is to ensure that you provide timely and effective care on a long-term, sustainable basis for the population via the LCG that you serve.

As part of that, we are actively looking at what incentives we might put in place in the context of that being delivered. The flip side would be potentially not paying for services when they are not delivered, but the point is well made: it is often easier to design the sanctions bit of this than to incentivise. The biggest incentive, though, and what has been very well-received — and these are discussions actively with clinicians, orthopaedic surgeons, urologists and others — is to give them a little bit more control over their day life.

I meet routinely with clinicians who say that if only they were untethered from all the bureaucracy and so on, they could do so much more for patients. As an organisation, supported by the Department, we are putting that challenge out to the clinical groups and saying, "Show us what that looks like. It needs to be within broadly acceptable parameters from a commissioning perspective, but show us what that looks like."

The Chairperson: We would like to be kept informed of that particular piece of work as it is rolled out.

Mr Sullivan: I am happy to.

Mr Stewart: I would like to make a couple of points to amplify Dean's answer. The ultimate incentive is to empower clinicians to make better and more efficient and effective use of the resources that we have. Central to that are mechanisms like integrated care partnerships, which members will be familiar with. I will give you a more local example of where this can be extremely powerful. Some work on medicines management, which was pioneered in the Northern Trust by Professor Mike Scott, is now being rolled out across all the trusts. I will not detain members with the fine detail of that, but I would be happy to send that to you. Essentially, some very progressive software packages have made a step change in the way the medicines regime is applied to patients in hospitals. As a direct result of that, the average length of stay in hospitals has been reduced by two days. Of course, that frees up capacity in hospitals to admit more patients and to increase throughput. That has come about through the empowerment of Professor Scott and his fellow clinicians in the trusts to innovate, to develop good practice, to have that recognised by the board and the Department, and to have it rolled out and replicated relatively quickly across the HSC, although I think that we could still do better in that regard.

The Chairperson: Thank you for that.

Mr Dunne: Thanks, folks, for coming in this afternoon. I have just a couple of quick things. Does your data include A&E waiting times and trolley wait times?

Mr Sullivan: Yes.

Mr Dunne: It does? Right. Briefly, without getting bogged down, how is that managed differently from the rest?

Mr Sullivan: One of the key ways in which it is measured differently is that we tend to track the waiting time side of things for planned care, which is what elective care is, on a weekly, fortnightly and monthly basis. We get live feeds on A&E waiting times, so colleagues in the board know now what the position is like across all the A&E departments in Northern Ireland. I get an update every morning at 9.00 am and another one at 4.00 pm to tell me what the position is, as do other senior board colleagues.

The principles are broadly the same. The principles are that we seek to identify the demand from patients in an LCG area for services, commission services consistent with that demand, and then hold providers to account for the delivery of the services that have been commissioned. So, the principles are almost identical to those for elective care. The key difference is that there is not the opportunity for the independent sector to deal with excess pressure in the system. For the demand that presents itself in the trusts, we are wholly reliant on the ability of trusts to deliver timely and effective services to —

Mr Dunne: The figures are fairly predictable, though, are they not? When we visited the Royal, we learnt that the figures are predictable. We always felt that they were unpredictable, but they gave us the assurance that they are fairly predictable. Why are we not managing resources better, then?

Mr Sullivan: Well, I can speak from a commissioning perspective. I am satisfied that we have worked very closely with trusts over a prolonged period to be reassured on the sufficiency of resource that exists in trusts to deliver timely access to care. That is not to say that there have not been and are not always potential opportunities to invest, on an issue-by-issue basis, in order to improve patient flow in the system. However, the resources are there now to deliver reasonable performance against the Minister's extant waiting time targets. That is easy for me to say today; the very real challenge is around actually delivering that, given the complexities in the patient journey and the challenges that the trusts have had.

As you say, Mr Dunne, whilst the front door is reasonably predictable and is actually fairly steady for the time-of-day and day-of-week demand, one of the remaining and continuing challenges for trusts is to keep their discharge performance equally steady during the days of the week and the times of the day. The greater the extent to which discharges are pushed later in the day and into the evening time, and the greater the extent to which the flow of discharges does not happen over the weekend, the greater the pressure on the front-door system through ED. As you will all know, ED pressures are only a symptom of the system itself not flowing through. At the end of the day, by definition, all patients eventually get discharged and, over time, admissions equal discharges. Having blockages in the system that prevent the flow from working as it should is only a timing thing.

Mr Dunne: Going back to the point about enforcement, is there a risk that front line staff are under excessive pressure to meet targets? We have had it at first hand from staff that, within wards, staff are told by managers, "These patients are going to breach". Is that putting patients and their standard of care at risk, because managers are more worried about breaching the target than they are about the condition of the patient or the level of care? Do you feel that that is an area of risk?

Mr Sullivan: If that were to happen, it would be an area of risk. Certainly, right the way through the system — from the highest level, going from the Minister down — any suggestion that we should be chasing targets rather than prioritising patient care would just not be countenanced, as the permanent secretary, the board's chief executive and trust chief executives said. Having said that, I can see that how, in extremis, suboptimal decisions might be thought about. That is just human nature. I reassure members by reminding them of the ongoing reminder reinforcement from the highest level in organisations, particularly the provider organisations, that patient care, outcomes and needs are paramount and the targets are secondary. That is not to say that the targets are not important measures, but when it comes down to the individual patient, it is about making the right decision for that patient.

The Chairperson: We also need to be mindful that we are dealing with elective care. We are straying into a conversation, albeit that it is an important one, about A&Es.

Ms Stevens: Chair, it actually reinforces the point that the two systems are interconnected. That is because this is about patient flow. So, they are relevant, and a whole-system approach is necessary.

The Chairperson: I think that the principles are similar. Some of the symptoms coming from those systems are different, however.

Mr Dunne: Dean, you indicated that you felt that too much effort is focused on meeting targets, rather than on dealing with issues such as TYC.

Mr Sullivan: I do not think, Mr Dunne, that I said that too much effort was expended on meeting targets per se. I think —

Mr Dunne: On initiatives, perhaps?

Mr Sullivan: This is qualified as always, and we are working in very complex systems, dealing with millions of patient episodes every year, but it is important that we ensure that there is as much or more of a focus on the transformation of services looking ahead as there is on the here and now. That is a juggling act of managing competing priorities, but that is where we have to be going. If we do not get the transformation bit right, we will go into some sort of a tailspin. What is a difficult performance now will become even more difficult in the future because of the pressures that we talked about. Just humour me by allowing me to come back to this, Mr Dunne: your point about unscheduled care is correct. The initiative that I talked about with the trusts, whereby we are saying to clinicians in trusts "Tell us what you would do differently", is a discussion about elective care primarily, but it also picks up unscheduled care. So, if it was in urology, it is about not just the planned patients but the emergency patients, because, clearly, a urologist, for example, deals with both. If I were to hold the mirror up to my approach to commissioning, I would see that it is maybe being too siloed down, in that we do elective care and we do unscheduled care. So, we all need to learn as we go forward and try to recognise that, at the end of the day, trust teams work as single teams and, therefore, it might unlock some opportunities for us if they think of things in the entirety of both the planned and unplanned work.

The Chairperson: Thank you very much. David, is your question about enforcement? Is it on the same theme?

Mr D McIlveen: It is, Chair; thank you. I think that Gordon Dunne has taken this discussion to an interesting place, and this question follows on from that.

Heather, you mentioned capacity in your opening comments. Obviously, capacity is very important. Am I right in thinking that, in that context, any suggestions to reduce capacity in the system at the moment would be, I guess, nothing short of irresponsible?

I have in mind a specific case. For some time now, the axe has been hanging over the Causeway Hospital in the Northern Trust, and there are concerns about the closure of certain departments. Might it not be helpful, in the environment that we are now in, for that axe to be lifted from Causeway? Some may argue that it is not there at all, but I think that most of us here, and there locally, know that it is, and that has caused capacity issues when it comes to medical staff actually wanting to be employed in the hospital. Nobody wants to work in a hospital that is about to be closed or that is going to have departments closed. Do you feel that it would be helpful, at this stage, if a very clear message was sent out regarding those departments that are facing a threat, whether they are ED or elective, and that that threat should be lifted?

Ms Stevens: That is a difficult issue for me to comment on. I think that it is very clear that the system's capacity is under pressure across the board. The work that the HSCB has done on the demand-capacity analysis shows that. Some specialties are under more pressure than others. The question of where the capacity that exists is deployed is an issue for individual trusts. Decisions on a range of things, not least the quality and safety for patients in the places where particular services are carried out, have to be made. So, I think that the location of services is a separate consideration, particularly in a jurisdiction the size of Northern Ireland. However, that is a different point from the overall availability and capacity that exists, which is certainly under pressure. So, you are absolutely right.

Mr D McIlveen: So, are you —

Ms Stevens: I cannot comment on the Causeway.

Mr D McIlveen: OK. Let me take it away from the specific. In general, do you accept that it would seem bizarre to the public to be, on the one hand, saying that we are already at the limit of our capacity, while, on the other, effectively reducing it?

Ms Stevens: I think that the public want a service that is timely and top quality. So, we need to put that service in place. I think that the public are probably more concerned with that than they are about specific location. They want the right service, and they want it to be to the highest available standard that we can provide.

Mr McKinney: I apologise for not being here for the start of your comments, but I caught the tail end of what you were talking about. I see some of the direction of travel, and I am slightly concerned about the idea of merely monitoring elsewhere. That leads me to the core of what I am asking, which is this: who exactly is responsible for managing and reducing waiting times in Northern Ireland?

Ms Stevens: First of all, the primary responsibility is on each trust to deliver on what it has been commissioned to do.

Mr McKinney: Can I stop you there?

Ms Stevens: Yes.

Mr McKinney: Who has the ultimate responsibility for reducing waiting times in Northern Ireland? Who has the strategic responsibility?

Ms Stevens: Ultimately, the Minister.

Mr McKinney: He cannot do that as part of his day job, so who does he defer to?

Ms Stevens: Absolutely. On a day-to-day basis, he defers to the board to manage the trusts' performance, and then the Department manages and monitors the board's performance as one of its arm's-length bodies.

Mr McKinney: Outline for me the clear responsibilities of the Department, the board and the trusts.

Ms Stevens: The trusts' responsibility is to deliver the activity that is being commissioned by the board. So, the board sets out the levels of service that it is giving money for, and the trust is contracted to deliver that. Dean explained the board's process for monitoring the delivery of the trusts' progress, and he discussed the fact that, in this year and last year, an element of funding was withdrawn, because, in certain specialities, the level of commissioned service had not been provided. So, there is a process there, which the board looks at. It has the demand-capacity analysis, so it knows when trusts are delivering to the levels that it expects.

On a monthly basis, the Department receives a report from the board setting out the performance against the standards and targets that we set. That is because, ultimately, it is the Department and the Minister's responsibility to set out the levels that we expect. We then hold the board to account for the work that it does to monitor the trusts. As well as looking at the work that the board does to tackle poor performance, we look at good performance, because there are areas of good performance. We look to see what can be done to share that more widely.

Mr McKinney: I could rephrase the question: who owns the waiting time problem?

Ms Stevens: We all do; it is a shared responsibility. Ultimately, the Minister is responsible.

Mr McKinney: I know, but sometimes sharing responsibility is a good thing, and sometimes it takes somebody to take charge. Has the Department ever considered putting somebody in charge to get this problem sorted?

Ms Stevens: In effect, that is what happens. We have a performance management process in place.

Mr McKinney: That is process. I am asking whether you have ever considered putting a person or a team in charge of dealing with waiting times, given the scale of the problem.

Dr Mooney: A number of people in the Department share that responsibility. Part of my responsibility is to make sure that the information is there to inform progress against the target. Part of Heather's responsibility is to chase up the performance management and oversight of the boards in their role of trying to manage the trust to be able to deliver that. The Minister and Department will set out clearly in a commission plan exactly what they want.

Mr McKinney: I understand that, but we have a problem. You value, as you said, the Committee's work. The Committee is bringing in evidence from elsewhere. It is interesting evidence, and it has to be evaluated. As I said, I am concerned that you are waiting for all this to filter down. If you were to change the system, surely you would need somebody in charge as a team. It would set some direction and send a signal that a mechanism was going to be put in place so that a difference could be made. Is there such a mechanism? Is there such a core responsibility either for dealing with this issue in the current way and achieving better outcomes or for changing it?

Ms Stevens: The teams are in place. In my team, one of my branches is responsible for —

Mr McKinney: Are they actively considering some of the mechanisms that are in, for example, Scotland, Portugal and elsewhere?

Ms Stevens: We have been monitoring the work the Committee has done, because —

Mr McKinney: No, that is our work. What is your work?

Ms Stevens: Yes. That will feed in to what we do. At this precise moment in time, we are gearing up for the assurance and accountability meetings that will take place over the next month or two so that we can be very clear about how the trusts are performing. As I said, this year is particularly significant, because we have undertaken to do an exercise that looks right across the trusts' performances and at

how they fared in quality and safety and in their financial process so that we can come to a view of the overall position. That is the point at which we make recommendations to the Minister.

Mr Sullivan: I will interject and say that, if it has not done so, it might be helpful for the Committee to look at tracing the story in Northern Ireland back to about 1995. There are lessons to be learned from the past. There is also the risk of reinventing things that have not worked and thinking that we are reinventing something that has worked. Most of the approaches that you are describing have been tried in one way or another. A service improvement unit was established in 2002-03, and there was quite a fanfare around it. However, it did not have a huge impact at the time. I was in the Department from 2004 to 2010 and was directly involved in an initiative that had a big impact. My personal view, and, I suggest, that of the board, is that I am not sure that having a single person in charge of this across Northern Ireland who acts in a different role to the structures that we have is necessarily the magic bullet that we are looking for.

As I said, the closest that the system gets to having an access point is the board. The board has responsibility, which is set out in legislation, for ensuring the delivery of the Minister's targets while working with trusts and being held to account by the Department. I have, hopefully, given a flavour of that already. I am as acutely aware as anyone around the table of the current performance not being acceptable, just as I was back in the Department in 2004, when we, not prompted by any wider process, put in place something that transformed things. I worked with Michael Bloomfield at the time; he was part of the team that I worked with in the Department. We will turn it around again. It is more difficult now. We face a lot more competing challenges on resources. The demographic position is massively different now as well. I assure you that we are thinking about all the things that we should be thinking about. I look forward to the Committee's recommendations, because we can always learn as well.

Mr McKinney: Of course, but I heard you say that you did not favour targets of terror and a robust approach. Now you are saying that you do not necessarily favour the individual approach. How are you evaluating that?

Mr Sullivan: Again, there is subtle difference in the words. I said that I would not like to get to a place where we were reliant on some terror arrangements, but I was instrumental in the introduction in Northern Ireland of not just elective care targets but the whole target regime that we have, which can be fed back to arrangements that were put in place in 2005 under my direction in the Department. So, I know the importance of having absolutely clear targets, of having robust monitoring arrangements in place that are linked to those targets, of having incentives and sanctions when those targets are not delivered and of having escalation arrangements. That is our mantra, our performance wail, and that is still where I am. What I was trying to convey was this: if all that you can rely on is the big stick and the threat of something when it is not delivered, it does not feel like a sustainable position for me. We have to get to a place where most of the time most of the things are routinely delivered and where we are not just trying in a big push to get over the line in a 12-month window. When I look back, I see that we made huge strides between 2005 and 2008 in unscheduled care, elective care, ambulance waiting times, cancer waiting times and so on and so forth. I encourage you to look at those numbers to see how much change can be made by the present incumbents. It is the same people there now, but the context is different.

Mr McKinney: I accept what you say, but I am just asking whether evaluations are being done on that. Clearly, the work that has been done has not arrived at the position where we would prefer it to be. There are other models out there, and the Committee has been looking at them. Had you looked at them, we would not have had to look at them. So, who is taking responsibility?

Mr Sullivan: I assure the Committee that I am personally taking responsibility for improving the arrangements that are in place between the board and primary care to switch off demand at source through maximising the skills that exist in primary care, not with a formal evaluation perhaps —

Mr McKinney: Should there be a departmental focus or a team whose job it is to enforce that? I use that word in its broadest sense. In other words, that is the job. Should there be another tier or another function to look at this and to ultimately resolve it? With respect, I hear what you say, and I respect the work that you are doing, but it is taking time, and the results are still not there.

Ms Stevens: I also think that is not just a simple case of putting in a team to sort out the elective care and waiting list problem. A whole-system approach is required. As was said, unscheduled care impacts on elective care, workforce planning impacts on elective care and the financial situation is

currently impacting on the delivery of those standards and targets. In effect, that one team would have to tackle the entire work of the Department. It would be too big for any one team to take on, but a team is in place that works with the board to monitor performance.

Mr McKinney: That is, however, substantially different from what I am talking about. Monitoring is different from leading, in that sense.

The Chairperson: Teams have been created elsewhere on this specific issue that did not necessarily have to look at the entire system. What I am hearing, Dean, is that people do not want to move to targets of terror. A special unit was set up that seemed to have had some impact, but then you acknowledged that it did not have the impact that we desired or wanted collectively. What is it that you, collectively as a Department or as a board, need? What is the ask in this question?

Mr Stewart: Investment, Chair.

The Chairperson: It is resources.

Ms Stevens: It is resources to provide the additional capacity that we know we need to meet increasing demand. However, on the other hand, it is about being able to manage down the demand as far as possible. We need to do both.

The Chairperson: You acknowledged, Dean, that it did not have the desired impact in, I think, 2004 or 2005.

Mr Sullivan: I would be happy — I am sure that departmental colleagues would be happy — to share with you the history of all the different approaches. The Department established a service delivery unit in 2006 that is now part of the board. It morphed from being part of the Department into being part of the board under the review of public administration phase 2 in 2009. That is still there today and is part of Michael Bloomfield's team, which I talked about before. The vast majority of the same staff still work there, all the performance information arrangements and so on are still there, and the same approaches to interacting with trusts are taken. As colleagues said, they were just working within a very different context at the time.

The evidence from the previous initiative, which was set up in 2002, is that it did not result in any material change to the numbers. The numbers moved in the way that Mr McKinney referred to from 2005 onwards through very specific focused inputs. We now find ourselves in a place that is more difficult and more challenging, but it is still fixable. If it would be helpful, Chair, I could outline to you what I believe are the five or six particular issues affecting performance in elective care. I do not know whether it would be helpful to have that information now or whether you would like us to drop a note to the Committee afterwards.

The Chairperson: We can take that information from you and reflect on it. On the point about strategic leadership, a special unit was set up, which, in your words, morphed into becoming part of the Department —

Mr Sullivan: Part of the board.

The Chairperson: Does that need to change?

Mr Sullivan: I do not believe so. If you said that the Committee's view is that there is not the necessary effective engagement with primary care at a senior level to change fundamentally the approach to demand management, I would say that the Committee was misinformed. However, that has applied at a very senior level, including Tom Black, only in the past number of months. That will bear fruit, I assure the Committee, later this year.

The Chairperson: With respect, Dean, it is not about engagement at that level. It is about the leadership, management and strategic direction of dealing with elective care waiting times.

Mr Sullivan: Let us go through the component parts of that. Why is there an elective care problem? One reason is that demand has increased by 12% in the past two years. Within that overall increase of 12% are significant spikes in particular specialities and/or particular LCG areas. We have to find a

way of sustainably holding demand at a manageable level. That is why I am personally having the strategic discussions with Tom Black and senior colleagues in primary care land, with a view to putting in place arrangements that will deliver that for us. You have seen the work that the board has done on demand and capacity. This is about getting to a point at which I know that there will be 2,000 referrals, not only in 2013-14 in specialty X in LCG area A but in 2014-15 and 2015-16, because that would be the nature of the arrangement with primary care to deliver that.

Separately, once we have a hold on the demand position, and at scale, for all specialties throughout Northern Ireland, we will have a hold on the trust side of things, which is the one that I described earlier. It is at scale within a specialty covering off planned and unplanned work. So, rather than getting into widget counting and counting individual bits of activity, we have a more strategic relationship with the trusts to deliver reasonable waiting times consistent with extant standards over that similar period. That feels like a position that covers exactly the sort of concerns that you raise, which are, I think, the right concerns, and you express those as, "not more of the same". We know that more of the same will not fix the problem. There is not enough capacity in the trusts and independent sector to continue doing what we need to do. We need to ramp things up in trusts by bringing clinicians to the fore and, equally, giving GPs much more of an opportunity to manage differently at their side.

Mr McKinney: That is all ambition. That is what you are aiming for. I do not want to crack the whip, but I want you to come up with imaginative ways of doing it differently so that the power rests with the people charged with that responsibility. Will power at that level make a difference? Does it exist now?

Mr Sullivan: I do not feel any lack of power, authority or ability to make change.

Mr McKinney: Yes, but long waiting times persist.

Mr Sullivan: That comes back to where we started. There are a lot of factors to bring to the table. It is useful to rehearse where we started in 2013-14, when I know, by specialty and by trust, the capacity of each organisation. I know, by LCG and by specialty, what the demand is expected to be. Where demand is expected to be more than the capacity, my expectation is that we will secure that, first, by additionality from within the trust and, where that is not possible, through purchasing capacity from the independent sector. That is where the year 2013-14 started.

Let us track the history of this. In 2010-11, 2011-12, and 2012-13, there were successive and significant reductions in waiting times. The year 2013-14 has been a poor year because demand has spiked in particular specialties beyond that which we had planned for. There was no contingency in our planning; we simply do not have the resources to send 100 patients to the independent sector and then send another 20 just in case demand is higher. This year, demand has been higher than we forecast; there have been some difficulties in the delivery of core capacity by trusts; and, crucially, in buying independent sector capacity, there have been, for the first time, some difficulties — certainly, for the first time to this scale — in identifying independent sector providers that can deliver certain types of work at the volumes that we require and, crucially, at a price that we can pay. Those three factors conflated, and all three were pulling in the wrong direction: under-delivery of core capacity; greater demand than forecast; and under-delivery of independent sector planned activity. Together, they generate, very quickly, numbers in the hundreds and thousands.

The Chairperson: Roy wants in on this same issue, and then we will hear from Chris.

Mr Beggs: There have been significant increases in a range of waiting list times for inpatient admission and those awaiting procedures. You seem to put that down to lack of capacity to outsource. Have you looked adequately at how you can more efficiently deal with spikes in-house? If there is virtually a monopoly in the private sector, why are you not increasingly doing that?

You say that there have been significant difficulties, including a resource issue, this year. However, the health service got over £100 million in in-year monitoring, which is more than ever before. So why has that happened?

Mr Sullivan: I will deal with the first question, about the ability of the system to deal with spikes in demand. The more mature arrangements with trusts that I referred to, which are a long-term strategic deal within individual specialties, are precisely that. Unless demand moves massively beyond reasonable expectations, my expectation and that of my LCG colleagues is that the provider would

respond to it. That is not the routine arrangement now; we are in more of a transactional, operational arrangement whereby the trusts' prime focus — not their only focus, but their prime focus — is on delivering activity. The waiting times are more of an outcome or product of all that. If trusts deliver activity, and demand is greater than that activity, the waiting time is what it is.

There are a number of draws on resources within Health and Social Care. I am sure that Committee members have been briefed on the fact that cost pressure is running at circa 6% a year; and increases in income are running at about 2% or 2·25%. Health and Social Care — across trusts, crucially, but also in pharmacy and primary care — has delivered cash saving and productivity improvements of £450 million cumulatively in the past three years. The system is running hard to stand still in some areas. I gave you an example of independent sector spend. Back in 2005 through to 2009, I was in a similar role to the role that I have now within the board and was in direct drive mode. We built in a much greater tolerance in terms of sending patients out to the independent sector because we could afford to. We could afford to deal with spikes in demand by building in tolerance and contingency.

If you look at the numbers, you will see that they were massive: in January 2007, 55,000 outpatients waited for more than nine weeks. By the end of March, it was about 25, so numbers were delivered down to zero or as near to zero as makes no difference. In the current financial context, it is much more difficult to do that. That is not to say that there are not huge pressures across the public sector. We know that there are, but we are here to talk about HSC.

Mr Beggs: I have not heard you talk about the value for money in simply farming everything out to deal with the —

Mr Sullivan: Sorry, Mr Beggs, I missed the start of that question.

Mr Beggs: I did not hear you address how you identify value for money in farming everything out. Every year, generally from January to March, a lot of work goes to the private sector. I am asking about the value for money of doing that rather than trying to find a more efficient way of dealing with it in-house: do you have the numbers to justify that? I —

The Chairperson: Sorry, Roy. One issue that we wanted to address was the role of the private sector, and we are moving into that. I know that Mickey and Pam indicated that they wanted to put questions on that. As their questions are in a similar vein, they can be addressed collectively.

Mrs Cameron: Thank you for your presentation. Use of the private sector is of great interest to the Committee and a key issue. The Committee has learned that in countries that have had success in bringing down waiting times, the private sector is used in a limited way. In England and Scotland, for example, the private sector is used to provide additional capacity at the margins and is not required year round. Portugal has a voucher system whereby, if a patient reaches 75% of the maximum waiting time, he or she is issued with a voucher that can be used in a private hospital. However, many experts pointed to potential difficulties in having a mixed public/private model of elective care.

What contracts exist with the private sector for elective care, how much are they worth and for how many years they have been signed up to?

Mr Sullivan: I do not have a list of every single independent sector contract. We can certainly let the Committee have that. Broadly, the spend on the independent sector has been in the £55 million to high £60 million range since 2009-2010. It was £57·5 million in 2009-10 and £66 million in 2013-14. The board and Department have made clear on numerous occasions their desire not to be reliant on the independent sector to the extent that we are. I know that the figures sound high, but they account for only about 5% of total elective activity, so they are small in absolute terms, but my view is that they are still too large and I do not wish that to be the position as we go forward.

I encourage Committee members to distinguish between the use of the independent sector to reduce long backlogs and what a sustainable equilibrium position might be. There will always be, from time to time and for various reasons, the need to clear a backlog — that was the case going back to 2005, 2006 and 2007 — and a desire to get to a point at which the system washes its own face. That is exactly what I was trying to describe earlier: our desire is to get to a place where demand in primary care and delivery in secondary care are locked down because the output of one is the same as the expected input to the other. It is my expectation that, in principle, we should be able to get there, or close to there, in the majority of specialties, with the exception of orthopaedics. The problem in

orthopaedics is of a different scale altogether: there are simply not the orthopaedic surgeons or the theatre capacity to allow us, straightforwardly, to respond to that from within the public sector, and there are other key constraints in Northern Ireland. So, there will, for some time, continue to be a need to utilise the independent sector. However, it is my desire and hope that, following the initiatives that I referred to earlier, we will be able to move to being less reliant on the independent sector and other areas. It is useful in exactly the way that you described it: at the margins when there is a particular issue to respond to. However, it is not useful as a sustainable, ongoing way of doing business. It is not how we wish to be commissioning routinely.

Mrs Cameron: Thank you. You have probably, partially, answered my next question. What is the Department's long-term approach to the use of the private sector?

Ms Stevens: It is as Dean has said. It is a necessary part of the picture in order to meet short-term need, but, ultimately, we want to be in a position in which there is not wholesale reliance on the independent sector.

Mr Brady: Thank you for the presentation. I am sure that I will be accused of repeating myself, but, if you were taking a cynical view of Transforming Your Care, you might consider that it is not so much a shift to the left as a shift towards privatisation. That is one view. Has the Department put in place any policies to prevent the same consultant treating patients in the public and private sectors?

Ms Stevens: There are workforce policies in place, and that is certainly dealt with in the consultants' contracts. Very stringent arrangements are in place. Doctors may combine work in the public sector with private sector practice, but it is regulated, and they must declare it. If they conduct private work in trust premises, the trusts ensure that they take back the associated cost so that they are not out any money as a result. That area is very closely monitored by the trust that employs the consultants.

Mr Brady: There is anecdotal evidence of consultants using public facilities in their private capacity and then, presumably — this is anecdotal — incorporating that cost within the charge for their private work.

Ms Stevens: They may well pass on the charge to the patient, but, ultimately, the public purse is not penalised as a result because the trust captures that cost.

Mr Brady: Ultimately, the patient may well be penalised. We have been talking all day about the patient being the priority, so that needs to be addressed. There is also anecdotal evidence of consultants who treat patients in the public sector passing on the information that they also work in a private capacity. That needs to be addressed, but is there anything in place to do that?

Ms Stevens: I am not aware of that, but we can look into it.

Mr Brady: As I said, the evidence is anecdotal. On a constituency basis, we deal with a lot of health issues, and I have come across this and the issue of consultants using public facilities for private work.

Ms Stevens: I am happy to take that back to workforce colleagues.

Mr Stewart: Chair, I will add to that briefly. We recognise the importance of the issue. There is always a tension between the capability of someone to work in the public and private sectors. That tension exists not only in HSC in Northern Ireland but in the NHS in other parts of the UK. In doing whatever we might do on that, we need to be conscious that the employment market is UK-wide, if not broader. So, if we were to make a change and, perhaps, restrict that further than is currently the case here in Northern Ireland, it could have an effect on the employment market and on our ability to fill important posts.

Mr Brady: I accept that, but we are saying that the patient is the priority. There is anecdotal evidence that some consultants are more interested in doing private work than they are in doing contractual work in the National Health Service. That needs to be looked at and addressed. You have to strike a balance. Ultimately, if we have a service that is free at the point of delivery, it seems slightly contradictory if people doing that work are allowed to do other work, which impacts on waiting times etc. That is surely one of the issues that we are trying to curtail.

Mr Sullivan: As Heather said, there is a very clear set of rules around the only basis on which consultants can undertake work in the private sector. It is after demonstrable evidence that they have delivered the expectations of the public contract.

Mr Brady: With any set of rules or regulations, enforceability is paramount.

Mr Sullivan: That is a big role for trust management.

The other point you made was about anecdotal evidence you have of the potential risk of patients being advised by consultants to see them in the private sector. I have no evidence of that, but I can see how, the longer the waiting times are, the greater that risk is, and greater, more generally, is the risk/need that patients will see that as a necessary evil for them. While they should reasonably expect to receive timely care in the HSC, they may feel that they have no choice but to go to the private sector. That takes us back full circle again; the prime objective for us is to fix that at source by not having long waiting times. If patients know that they are going to be seen in outpatients within nine weeks, there would be little or no incentive for them to pay privately to be seen.

Mr Brady: But you can see why that can happen. You are reducing your resources and capability if someone is being given that offer. Ultimately, surely one of the issues is to protect the National Health Service. It is one of the few bastions left that needs to be and should be protected at all costs. It seems that the move towards privatisation is totally undermining what has been and continues to be a very good service. We look at the negatives, but, sometimes, we have to look at the positives.

Mr Sullivan: Certainly, in the context of the discussion we have had today, there is categorically no move towards privatising anything. It is quite the reverse. In all the initiatives that I have talked about in primary care, the desire in the public sector and secondary care is that they would offer a more holistic wrap-around service and deliver the outcomes that patients expect.

Mr Brady: What this space, then.

Mr Sullivan: Yes.

The Chairperson: The issue is not about the tension that you referred to between public and private. As you rightly pointed out, it is more than a tension; it could potentially be a conflict. You are saying that there is no appetite to move towards greater privatisation than already exists. In Scotland, for example, certain boards do not use consultants from their particular areas. What are you doing to ensure that that conflict does not exist? I hear workforce planning, but there has to be something more than that.

Mr Sullivan: There are a number of subtleties in the different ways of asking the same question. I will try to answer it from my perspective of what I think the issue is. If what we are saying is that all of us — you, as elected representatives, and colleagues and me in our respective day jobs — need to be assured that what I am commissioning from the public sector — from trusts, from within trusts and, ultimately, from individual consultants — is what we actually get, then, clearly, we do. That is why we have the transparency that we have all the way down to the number of diagnostic tests, outpatient appointments, review appointments and so on and so forth. That was built from the bottom up on the basis of the number of consultants, how many sessions they have and so on and so forth. Notwithstanding that transparency and clarity, I flagged it up that some of the limitations with that approach are that it is a bit operational, a bit transactional and, bluntly, does not necessarily motivate consultants to get out of bed in the morning. If we are not careful, all we collectively do is to turn their job into a series of individual patient episodes as opposed to a more holistic caring for a wider population and group of patients. That has been the approach on that side of things.

As for getting more capacity into the system and avoiding a tension/conflict between the private sector and the public sector, we have sought, through our commissioning of independent sector capacity, to make as much use as possible, within procurement rules, of capacity from outside Northern Ireland, be it from the Republic or GB. That is simply to try to draw in more capacity, reflecting the challenge that you are putting on the table, which is that we are just cycling the same work around the same group of staff. We are trying to bring genuine additionality to the system, and we have actively been pursuing that as a strategy.

The Chairperson: One of the things that we were becoming aware of was the cost of using the private sector. Here in the North, across the island and in England, it is much more expensive to use the private sector. Some of the experts indicated to us that civil servants, with respect, are not trained negotiators or practised at achieving good deals with private providers. How do you address that?

Mr Sullivan: I will try to address it. The starting point has to be that, in a position where it is a fact that demand exceeds capacity, we have a choice: either we can have longer waiting times than we do; or we can secure additional capacity from another provider. The only other provider that is readily and straightforwardly accessible for us is the independent sector. So, first in the order of things, we need to get past that. I am happy to have a separate discussion about why there is any capacity gap and what we might do about it.

The Chairperson: No. That is not the question that has been raised.

Mr Sullivan: I realise that. I was going to get —

The Chairperson: The question that has been raised is this: what can the Department and the board do in relation to dealing with that conflict?

Mr Sullivan: Right. Second in the order of things is about getting value for money from the independent sector. We have a framework contract, and no company can be on that framework contract unless it is committed to delivering services for the English tariff. Civil servants across the water — as able as my colleagues who sit beside me — drawing on lots of procurement expertise, have agreed, over a long time and through a very robust process, a reasonable price to be paid for individual procedures. We do not try to invent that wheel locally; we simply use it. There is an orthopaedics tender out at the minute. Whilst providers are free to bid at whatever price they wish for that orthopaedics tender, from our perspective, we have a clear frame of reference for what would be a reasonable price to pay, consistent with the tariff. I believe that, providing that and for as long as we secure prices from the independent sector that are at or below tariff, we are securing value for money from the use of the independent sector. Generally, we have been successful in doing so, but I mentioned, in response to a previous question, that we have had some challenges in some specialties in doing that of late.

A separate question is whether better value for money could be secured from delivering the services within the public sector. Perhaps, probably. However, that is a separate question, given where we started the discussion from.

Mr Beggs: Let me reinforce the point that, in order to get value for money, you should at least be testing what local clinicians, teams of nurses and allied professionals can provide the service for. I have heard criticism of some of the work subcontracted, because it does not have the same level of follow-up as is possible when locals carry it out. We are seeking confirmation that you are open to enabling teams to do that and to build and improve their existing teams for the long-term.

Mr Sullivan: Absolutely. In response to a question on how we respond to gaps, I said that the first thing we do is to seek, from the in-house team, whether they can, as a non-recurrent, one-off initiative, do something more. Holding a mirror up to the approach that we have, we ask whether there is more that we can do, even than that, to energise those teams. Unencumbered by such bureaucratic, limited thinking that we may directly or indirectly be imposing on them — untethered from all that — they are asked, "Show us what you can do. If you can demonstrate to me that, following all demonstration of good practice that we would expect to see at outpatients, one-stop shops and access to diagnostic tests and so on and so forth, there is a resource bill at the end of that but that, in return, we receive significantly greater throughput than is currently the case, we are all ears". So, yes, absolutely, Mr Beggs.

Mr McKinney: I want to delve into that a wee bit further. Given that the private sector exists and the public sector exists, what would be the motivation for somebody to squeeze more out of the public sector in productivity, if the private sector is there to pay some of those people to do it elsewhere?

Mr Sullivan: You could have separate discussions with some clinical teams and that would be helpful to reassure you how committed those teams are to trying to do the best thing within the public sector. There are always exceptions, but the vast majority of clinicians want to do the best for patients within

the public sector. They think that they can do that and do private sector work at the margins, rather than the two being in conflict, as the Chair referred to.

Mr McKinney: Do you, then, routinely measure the extent to which public service contracts or consultants work in the private sector? Are you aware of the scale of that? Do you get feedback that person x works x hours there, whenever they work in the private sector? Do you know that?

Mr Sullivan: I would not know that individually, but what I mentioned earlier —

Mr McKinney: Does the system know that?

Mr Sullivan: An individual trust would know that, because there is a set of rules about what a consultant must deliver before he or she is able to work in the private sector.

Mr McKinney: But do you then know the scale of the work they have done in the private sector?

Ms Stevens: We know that we are paying about 6% of elective spend in the independent sector.

Mr McKinney: No, that is the total. Surgeon x is working in the public sector and is contracted for x days a week and x number of operations. Do you know how many operations that individual is doing routinely in the private sector?

Mr Sullivan: I do not think that we would know that at an individual consultant level. The trust would know clearly what work that individual is undertaking within the public sector contract. The individual's employer in the private sector would know how much work they are doing in the private sector. The individual is accountable for ensuring that their working hours do not exceed the working time directive, which is the sum of both of those. To an extent, they are separate from each other.

Mr McKinney: Given that we are talking about waiting times, is that not valuable information?

Mr Sullivan: What would we do with that if we had it, Mr McKinney? Let us say that I am a consultant, and I do 11 PAs within the public sector and three PAs, half-day equivalents, within the private sector, I am not quite sure what I —

Mr McKinney: But we do not know.

Mr Sullivan: But I am not sure what I would do with it if I did know or even whether it would be within my gift to —

Mr McKinney: Given that we are spending millions in the private sector, it might encourage us to think differently about how we do our work and how we negotiate with consultants overall, but we do not know the information, so we cannot make a judgement.

Ms Stevens: The trusts know the information in relation to their —

Mr McKinney: Does the Department?

Ms Stevens: We can ask the trusts for information.

Mr McKinney: No. This brings me back to the responsibility thing.

Ms Stevens: No, we do not have that level of detail.

Mr McKinney: You do not have it, Dean; and you do not have it. Who is responsible?

Mr Stewart: Not all the work that consultants do in the private sector is paid for by the public sector. Some of it is fully private.

Mr McKinney: That is true, too, and given the conflict that we have talked about notionally here, would it not be valuable to have that information? I raise this because it underscores for me the issue

of the responsibility that we talked about in terms of at departmental level or banging up against the Minister.

Mr Sullivan: If I might challenge you, Mr McKinney — genuinely, I find a lot of the discussion today helpful, and there are ideas that we will take away — I am trying to work out what I would do with that. Let us use the example that we mentioned. One provider that we use a lot within Belfast is 3fivetwo Healthcare. If I know that consultant x, a surgeon, was doing his or her 11 sessions within the public sector in Belfast Trust, I know what that needs to look like because I have numbers that tell me how that adds up for him or her and the team. I know that I am getting that, or I know if I am not getting that, so I know that already. Equally, if I were commissioning from 3fivetwo, I know what I am meant to get from it as well, as an organisation that I am commissioning from. I am trying to work out what I would do with the information, if I knew it, for an individual consultant who happened to be working in both bits of the system and, as Chris said, maybe some of the work that he was doing in 3fivetwo, as a particular provider, could be pure private sector work and some of it could be funded. I will reflect on that. I am not sure what I would do with that if I had it.

The Chairperson: Would that information not also give you an insight into an individual having an appetite to work in that field, and, therefore, could that person not be given the additional hours in the public sector?

Mr McKinney: It goes back to your point about squeezing that extra bit out of the public sector and getting teams to imagine how they would work differently.

Mr Sullivan: I think that that is right. There are consultants who, for a whole combination of reasons, do not want to do anything beyond their 10 PAs. It certainly would give a flavour of those consultants for whom 13 or 14 PAs in total is the working arrangement that they would like to have. I come back to the approach that I talked about, which is the one unencumbered by all the bureaucracy and so on, where a team of surgeons, urologists or whatever tell us how they might deliver things differently for us and we see whether that motivates them in a different way, rather than the way in which we have been commissioning.

Mr McKinney: I think that even your last response indicates that you would see value in the information that I am talking about.

Mr Sullivan: I am not sure that I necessarily would, bearing in mind what that discussion looks like. Let us say that there is a team of five urologists at the top of the table, for example, and I am passing the challenge across to them and asking them to come forward with something radical for me. The risk for the process that I described earlier of doing what you are describing is that I am getting back into my bad old ways of wanting to second-guess everything. What the team of urologists should be saying to me is, "Dean, get off the pitch and let us get on with this. We will come forward with a radical solution." The more we micromanage and the more we operationalise things, the greater the risk of us getting what we have always got, because that has been the approach to date. We know everything that moves in unscheduled care and elective care by trust, by site, within trusts and all the rest of it. I am suggesting — hypothesising — that a different approach that is more hands-off might be helpful. There might be key information in there that might be helpful either for me or the trusts. I will reflect on that. However, we are primarily trying to empower clinicians rather than second-guess them.

Mr Stewart: One recent example of where we have seen that happening successfully was in Canterbury in New Zealand. It came about for a particular reason. There had to be a fundamental change in the way in which care was delivered, because the earthquake knocked down a lot of the buildings. There was a sudden disruptive need for change. The analysis of that, which has been done by the King's Fund and others, points to the very fact that Dean is emphasising, which is that changes were clinically led. It was not characterised by a targets and terror regime. There was, of course, robust monitoring of performance, and there still is. However, primarily, the change in the pattern of services and in the way in which the services were delivered was led by the clinicians, and it is seen as having been very successful because of that. There is now effective management of waiting lists and waiting times in Canterbury.

Mr McKinney: Let us hope that it does not take an earthquake.

Mr Brady: I just want to make a comment, and I do not expect you to comment on what I am saying. It seems to me that, around the whole issue of privatisation, there is a perception that — this is predicated on the perception abroad — the current British Government are intent on, if not already involved in, dismantling the welfare state as we know it. There is no doubt that that would have a knock-on effect. I would not necessarily be of that opinion at the moment, but there is a notion abroad that that process is happening. When you look at Transforming Your Care, you can see what it could become and, in some cases, that reinforces that notion. However, I do not expect you to comment on that necessarily.

Mr Stewart: I think that any civil servant should always be very hesitant before putting themselves in the place of the Minister, but, if the Minister were here, I think that he would say very clearly that he has no agenda for privatisation and that that is not what TYC is about.

Mr Brady: With respect, the point that I was making is that the Minister is not a member of the British Government, but it will have a knock-on effect possibly.

The Chairperson: OK. Thank you for your presentation. It has been a useful exchange. It probably leaves us with a number of questions. Obviously, the Committee is about to go into a process of making recommendations. The key message that I took from this was about the shift in the referral to treatment time. We have not been given a sense of what a realistic time frame for that might be, and we look forward to getting that clarification from you.

There is also the issue of the enforcement of targets. Whose responsibility is it to enforce those targets? What are the policies around incentives or the developing policies around incentives? Equally, the management of this piece of work is a huge issue. Where does it sit; does it need another team; is there a lead body; is that strong enough; and what lessons have been learned from the 2004-05 processes?

There is also the issue of private sector involvement in relation to the investment that is there and how that can be used to assist, support and enhance the workforce in the health service and, equally, how we can use that information to ensure that the conflict that exists on some occasions between the public and private sectors is eradicated.

We will continue to have those conversations. Thank you very much for your time today.