Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Budget 2016-17 and Waiting Times in Emergency Departments: DHSSPS, Health and Social Care Board, Public Health Agency

13 January 2016

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Alex Easton (Deputy Chairperson)
Mr Thomas Buchanan
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Kieran McCarthy
Mr Michael McGimpsey
Mr Fearghal McKinney
Mr Gary Middleton

Witnesses:

Mrs Deborah McNeilly	Department of Health, Social Services and Public Safety
Ms Julie Thompson	Department of Health, Social Services and Public Safety
Mr Michael Bloomfield	Health and Social Care Board
Mr Dean Sullivan	Health and Social Care Board
Mrs Pat Cullen	Public Health Agency

The Chairperson (Ms Maeve McLaughlin): Thank you, folks, for attending. We have Deborah McNeilly, deputy secretary, healthcare policy group, at the Department; Julie Thompson, deputy secretary, resources and performance management, at the Department; Mr Dean Sullivan, director of commissioning at the Health and Social Care Board (HSCB); Mrs Pat Cullen, assistant director of nursing, safety quality and patient experience at the Public Health Agency (PHA); and Mr Michael Bloomfield from the Health and Social Care Board. You are very welcome. I invite you to make your opening commentary, and we will open it up to questions and our comments.

Ms Julie Thompson (Department of Health, Social Services and Public Safety): Thank you, Chair. I will provide the opening remarks on the 2016-17 budget processes, and Deborah will give the opening remarks on emergency department (ED) performance.

For 2016-17, the Department's expenditure budget has been set by the Executive at £4·9 billion, representing an increase of almost £129 million compared with 2015-16. In recognition of the many challenges facing health and social care, the Executive have protected the Department's health and social care budget allocation for 2016-17. Whilst that is very welcome, the Department and its arm's-length bodies (ALBs) will have to identify substantial savings in order to supplement that additional budget allocation and deliver services within the budget, which underlines the importance of the reform agenda.

The Department's financial planning processes for 2016-17 are in progress. They include our undertaking a comprehensive assessment of all the pressures that need to be addressed in 2016-17 and ensuring that services are provided in line with ministerial priorities. The financial planning process is also aimed at identifying all available opportunities that could be deployed in seeking to manage a challenging financial position whilst securing delivery of reform and transformation. That includes exploring opportunities across all the Department's ALBs, family health service and the Department's own administration and programme budgets.

The Executive have set a capital investment budget of £233 million for the Department in 2016-17. That includes £10 million of financial transactions capital for investment in GP infrastructure and £16 million of ring-fenced funding for the regional children's and maternity hospital in the Royal. The 2016-17 capital allocation allows the Department to continue with a range of important infrastructure schemes and will finance investment in ICT, medical equipment, fleet and estate of the ambulance and fire services, and maintaining the extensive Health and Social Care (HSC) estate.

Mrs Deborah McNeilly (Department of Health, Social Services and Public Safety): The Committee requested that we use this session as an opportunity to brief you on emergency departments' performance and progress against recommendations made by the Royal College of Emergency Medicine (RCEM) in 2014.

I would first like to pay tribute to all our staff who work on the front line in emergency departments. There is no doubt that winter is a challenging time for health services across the UK and Ireland, and our emergency departments faced considerable pressure over the busy holiday period. The briefing paper provides a high-level overview of performance in the first weekend in January. As the figures show, it was busy, with attendances up by 8·2% overall. Despite that, it is notable that our escalation plans worked. There were no major incidents and at no point was patient safety compromised.

Late in 2014, the RCEM prepared a report with 18 recommendations for reform and modernisation in unscheduled and emergency care services in Northern Ireland. It was in recognition of the need to consider that work, in conjunction with the recommendations of the Regulation and Quality Improvement Authority (RQIA) report on unscheduled care, that the unscheduled care task group was established. That group has now moved into a new phase aimed at embedding improvement initiatives under the leadership of the chief executives of the Health and Social Care Board and the Public Health Agency.

The group has made real and meaningful improvements in the experience of care for patients accessing unscheduled care services. The briefing paper highlights many of the innovative pieces of work that we have developed and continue to implement, which will strengthen and improve our urgent and emergency care services. They include improvements in direct access for patients, helping them to bypass ED; the work with Marie Curie to introduce an extension of the seven-days-a-week, out-of-hours, rapid response palliative care service; increased provision of hospital ambulance liaison officers at emergency departments to help with turnaround; and the establishment of an agreed regional process for patient admission from ED in all hospital sites that reflects local needs and capacity.

As I said, however, significant challenges remain, and it is important that we continue to work hard to address them.

The Chairperson (Ms Maeve McLaughlin): OK, thank you for that.

Moving back to you, Julie, what are the Minister's priorities for the 2016-17 budget? You will have heard me raising this on a few occasions.

Ms Thompson: The Minister has set out his priorities in terms of a focus on reform and transformation, improving the health and well-being of the population, and looking at the quality of health and social care. Included within those is looking to see what we can do with elective care; unscheduled care, in terms of ED performance; the creation of a transformation fund, which he has discussed; and then, obviously, the reform aspects around the work that the panel will be moving into, as well as the restructuring around that.

The Chairperson (Ms Maeve McLaughlin): Sorry, can you go over those three again? Reform and transformation.

Ms Thompson: You have reform and transformation, elective care and high-quality service provision, and unscheduled care transformation. Those are all part of the Minister's vision, as has been set out in the briefing document.

The Chairperson (Ms Maeve McLaughlin): Sorry, I am just not clear. Are you saying that the elective care and unscheduled care come within reform and transformation? Or is that —

Ms Thompson: I am saying that that is part of where he wants to look at the quality of health and social care.

The Chairperson (Ms Maeve McLaughlin): But there are three priorities.

Ms Thompson: There is a range of priorities, which the Minister has set out in the speeches and statements that he has made. They are summarised, I guess, in paragraph 2 of the briefing paper. From the essence of what he has said, this is what he wants to have in place, as we look forward. These are the things we need to look at. That is why I am drawing it out for you around what that means.

The Chairperson (Ms Maeve McLaughlin): I am trying to draw it out as well. If I was to ask you, specifically, to give me the top three priorities, what would you say?

Ms Thompson: That is a question for the Minister, but the articulation in paragraph 2 is what the Minister has said about what he wants to do. He certainly wants to have a high-quality Health and Social Care. He wants to look at access. He wants to look at reform and transformation. Those are all part of the Minister's vision. There are various aspects to that, from the things that he has set out, that we are working our way through.

The Chairperson (Ms Maeve McLaughlin): I suppose that all of us would say that. Nobody would disagree with quality of care and reform and transformation. However, when we are allocating budgets alongside priorities, what would the key ones be?

Ms Thompson: I guess, around that process, as we have discussed before, what we need to look at is the services that are already on the ground, the cost of those services and whether those services are what would be needed in meeting ministerial priorities in the future. That may lead to the need to reform or transform those services, and then, obviously, looking at savings opportunities. Having looked at the envelope that is needed for that element, it is a matter of establishing, for moving ahead, what more resources could be put into particular areas. That conversation with the Minister and the detail of working through those allocations has yet to happen as part of the budgetary process. We are gathering together all the information at this stage, but, having just received the budget allocation, we are not at the point where final allocations are ready to be made.

The Chairperson (Ms Maeve McLaughlin): We are dealing with just a year's budget, as well. You would think that those priorities would be very close to being finalised.

Ms Thompson: We only got the budget allocation on 17 December, which was only a couple of weeks ago, with Christmas and that, so we are working through all that with the Minister at the moment. That will allow those decisions to be made on allocations, but it will take another few weeks to enable that to happen.

The Chairperson (Ms Maeve McLaughlin): Coming at it from a different angle, what are the major changes in budget allocation that we will see in this budget, as opposed to the last one?

Ms Thompson: As I described, we are working through those processes at the moment, so we are looking at every aspect of the budget. So you go right through from the trust perspective, where they are looking at the services that they currently provide and developing their savings plans. Those are not finalised at the moment, but they are working on them. They are looking at the scope within those plans for a wide range of savings. We then need to look at all the remaining parts of the budget, whether it be for the small or arm's-length bodies or the Department's budget, and all scope for pressures and opportunities coming through. That is the process that we are working on at the moment. We are not out the other side of that and into final allocations as we speak today.

The Chairperson (Ms Maeve McLaughlin): It seems very late in the day.

Ms Thompson: Obviously, we have £4·9 billion, and we have just been advised of that final budget allocation, so we are working through those processes. It will be sorted out within a few weeks, but it is not there just at the moment.

The Chairperson (Ms Maeve McLaughlin): I want to ask about the reform agenda. Is there an allocation in this budget for a voluntary exit scheme (VES)?

Ms Thompson: At the moment, no, but that is not to say that there could not be one. In the 2016-17 processes, some allocations have already been made for voluntary exit, but further bids for voluntary exit can be done in the June monitoring process. From our perspective, we need to understand from the trusts their plans and, therefore, what access they wish to have into the voluntary exit scheme. We will make those bids as part of the June monitoring process, and that is allowed as part of the processes moving ahead.

The Chairperson (Ms Maeve McLaughlin): I find that slightly difficult to understand fully, because we are talking about major reform of the system and huge, significant shifts, such as the closure of the board and the relocation of staff. If we are honest, it cannot be the relocation of all staff to either the Department or the PHA, so why are we not preparing for a voluntary exit scheme at this point?

Mrs McNeilly: There is an ongoing voluntary exit scheme for 2015-16, and there will be a number of people from the board who will go through the existing scheme, for which the Department has funding in the current year. That gets them ahead of the curve, in the context of change. They still have to maintain services and business during 2016-17, because, obviously, they will have legislative responsibilities and, therefore, they cannot stop; they will still have to fulfil legislative and accounting office responsibilities. There will be staff who will exit in 2015-16, or very early in 2016-17, and those staff will be funded from the current funds that we have in 2015-16.

We are working through the 2016-17 scheme, and we will get funding for it at June monitoring. Initially, in terms of allocating the funding out of our existing budget, we have been advised that we will be able to bid for that in May and that we will be able to secure funding. In light of the experience of the current process, we have been provided with assurances. The spend on VES, in the current year, across the whole system — for trusts, our arm's-length bodies, the PHA and the board — is in the region of £10 million. I would not anticipate a huge increase in the funding that we might require for voluntary exit next year across the whole of the HSC system, including the board, the PHA and other ALBs — a £10 million bid.

The Chairperson (Ms Maeve McLaughlin): Are we saying then that, realistically, you do not see a significant change in the current staffing levels?

Mrs McNeilly: The Minister has been clear that this is not about staff; this is about structures. There will be numbers exiting in the current year. Those numbers are yet to be confirmed, but there will be —

The Chairperson (Ms Maeve McLaughlin): I am sorry; I am trying to be clear on this. There will be numbers exiting in the current year, and you will bid for these in a monitoring round?

Mrs McNeilly: No; for any more that we need over and above —

The Chairperson (Ms Maeve McLaughlin): Do you have a calculation of what that scheme will cost?

Mrs McNeilly: It is a very rough calculation, because it is too early to tell at this stage. A very rough allocation for the whole of the HSC next year would be that £10 million is the middle range, based on the experience of the current year.

The Chairperson (Ms Maeve McLaughlin): That is obviously a calculation of staffing changes.

Mrs McNeilly: It was only a rough estimate, but if we take a 10% reduction in staff numbers in the board, that is where the £10 million comes through. That includes the numbers coming through from all the trusts and all the other arm's-length bodies. It is a very high-level estimate.

The Chairperson (Ms Maeve McLaughlin): So, it is a 10% reduction in staff across the HSC.

Mrs McNeilly: That just factors in 10% in the board.

The Chairperson (Ms Maeve McLaughlin): And that is costing around £10 million.

Mrs McNeilly: No, much less. This year, it is probably about £3 million. Of its share of the £10 million next year, it is maybe about £3 million.

The Chairperson (Ms Maeve McLaughlin): But it is likely to be higher than £10 million.

Mrs McNeilly: We looked at the estimates in December. We have had difficulty with this. We got returns in from our trust colleagues based on the high-level assumptions around budget. We then asked the board what the implications of a 5%, 10% and 15% reduction in its budget in 2016-17 would be and applied that directly through to staff, because it is all admin saving reductions in the 5%, 10% or 15% options. We applied that fully to the staffing numbers in the board, added that into the calculation and took all the trusts and arm's-length bodies together, including the board. We took a 10% reduction in their staffing costs into account. Overall, across the system, £10 million was the middle.

The Chairperson (Ms Maeve McLaughlin): I assume that that calculation would be done in a regular voluntary exit scheme process. However, this is a hugely significant proposed reform of the system.

Mrs McNeilly: Yes, I agree, but the Minister has been clear several times in saying that there will be no voluntary redundancies and that he sees functions being moved around and transitioned into the trust, the PHA or the Department. There will be reductions this year, which will bring the numbers down, and there will be access to a voluntary exit scheme next year. We have asked the board what the impact of a 10% reduction in its budget would be and, taking that directly through to its salary cost budget, what a 10% requirement for VES would be. That has fed into the overall number, which is a very high-level estimate of £10 million for access to VES.

The Chairperson (Ms Maeve McLaughlin): There will be no access to VES until the 2017-18 Budget then.

Mrs McNeilly: In 2016-17, we will have access to VES funding.

Ms Thompson: We will use the next few months, between now and June monitoring, to firm up all the plans to move from that high-level estimate into something more definitive. All organisations will then know what their plans are and what access to VES they will need. We will put that in through the bidding process into June monitoring and the moneys will come out the other side.

The Chairperson (Ms Maeve McLaughlin): As it stands today, it is not reflected in what we have in front of us for 2016-17.

Ms Thompson: No, we have no allocation at this stage, but it will come through as part of June monitoring, and we will use the next few months to firm up what we need to access.

The Chairperson (Ms Maeve McLaughlin): Is this not symptomatic of a real, core issue in the Department and the over-reliance at times on monitoring rounds?

Ms Thompson: The processes allow this. There is nothing unusual about that for this Department. The VES was either to be accessed right now up front or could be accessed as part of the June monitoring. We have had conversations and discussions with DFP, and, from its perspective, there is absolutely no issue with the timing. It is better to work it through properly, do all the detail and understand exactly what we need access to. That work will happen, and we will then be able to log those bids more accurately when it comes to June. DFP has absolutely no issue with that, and the funds exist at the centre to enable that to happen.

The Chairperson (Ms Maeve McLaughlin): Do you expect that, by June, somebody will have the blueprint for what is required in staff changes and in cost requirement?

Ms Thompson: In logging the bid around VES, we will have to be clearer about the staff implications right across the system and therefore the extent to which we need access to VES. That work is ongoing in trusts, in the board and in other ALBs, and it is about asking, "What does this mean?". We need to work through on the budget side and translate that into the staffing implications. That will then lead to an understanding of VES. There is absolutely no issue with where DFP would like us to be on that process and what we need to do to access the money.

The Chairperson (Ms Maeve McLaughlin): I want to ask about the context of all this. The paper talks about the trusts' savings plans being processed in partnership or consultation with the HSCB. Why would we be doing that at a time when we have acknowledged that trusts need to be brought more within the Department's remit in terms of accountability?

Ms Thompson: We are working with the trusts. There have been direct conversations between the trusts and the Department. The board and the PHA still have roles to perform, and they are still performing those roles. That said, we are looking at the trusts developing those plans and being given sums of money more flexibly as we move into 2016-17. We have just not quite fully reached that stage of the process. The trusts are effectively owning their allocations and what they do with them. That said, the board and the PHA still have functions to perform, and we expect them to do that. They are looking at it across the piece to see whether savings proposals are in line with the commissioning intentions and strategic direction and whether there is a consistency of approach across the trusts and all of that sort of thing. We are working collectively with board and PHA colleagues on that as we look at the plans.

The Chairperson (Ms Maeve McLaughlin): On unscheduled care and specifically the increase in waiting times, how much of this is down to poor performance from the board?

Mrs McNeilly: This is increased demand across the system. This is a system that is under pressure, and it is also under pressure in other regions. A hugely significant amount of work has gone into unscheduled care over the last 18 months to two years. The Minister indicated earlier this month that, without all those actions, we would have been in a much more difficult place for the return in January. You will be familiar with a lot of the ongoing work on pathway reform, EDs and direct admission units. When we looked at the information coming back for the first weekend of January, which is just a snapshot of a very busy time, we saw that some EDs were faced with a 25% increase in attendances and others with a 15% to 17% increase in attendances. The information coming back to us is that 92% of patients had a very positive experience because they were looked after and cared for.

The Chairperson (Ms Maeve McLaughlin): Explain to me then why the performance report from the HSCB in December showed a 7% shortfall in both outpatient and elective care.

Mrs McNeilly: This is elective care, not unscheduled. In elective care, there has been an improvement in core delivery and core capacity. The last time that I was here, we talked about the numbers for 2014-15. Keep me right if I get any of the numbers wrong. In 2014-15, there was an under-delivery of 7%. The latest update that we have is that we are sitting at 6% this year, so there is an improving picture here. As we discussed the last time, there are huge pressures in elective care. If unscheduled care pressures increase, with more admissions and more people turning up to ED, that knocks back the capacity in elective care. For example, there are more general surgery operations done in certain trusts at certain times, but that is at the cost of elective care because they are taking forward unscheduled care.

The Chairperson (Ms Maeve McLaughlin): But there is a 6% performance —

Mrs McNeilly: That is an improvement on where we were in August and on where we were —

The Chairperson (Ms Maeve McLaughlin): But it must put pressures on the system.

Mr Michael Bloomfield (Health and Social Care Board): The figure that you are quoting is from the board's December performance report. If we look at the earlier position in the year, back around the first half of the year up until the end of September, we see that there was about an 8% to 9% shortfall in the delivery of core volumes. That reflects the particular issues over the summer period. As Deborah has alluded to, we can now look at the first eight months of the year, which is an updated position from the one that you are looking at. In the same period last year — 1 April 2014 to 30 November 2014 — there was an under-delivery of 7·5%. In the same period this year — 1 April 2015

to 30 November 2015 — there was an under-delivery of 5·8%. That is an improvement of over 1·5% and equates to many thousands of additional patients being seen than in the same period last year. That reflects the real focus across the trusts and from the Health and Social Care Board on ensuring that we maximise the efficiency of the capacity in the system. The under-delivery of core capacity or core volumes in a number of those areas will be for understandable and legitimate reasons, such as being unable to fill key posts and staff being off on maternity and sick leave and being unable to backfill. We look at all the specialties in all the trusts where core capacity is under-delivered and challenge them, understand the reasons and seek improvement plans. We are seeing the benefits of that when we compare this year with last year.

The Chairperson (Ms Maeve McLaughlin): Substantial work is ongoing on emergency departments, but I cannot see any notable improvements, with the exception of the Royal. I hear from you today that it is demand-led. Does demand account for the fact that the number of patients waiting in emergency departments for over 12 hours has doubled in the last year?

Mr Dean Sullivan (Health and Social Care Board): You can look at lots of periods in terms of 12-hour waits and other measures. I am not aware of numbers having doubled. The briefing paper looks at the Christmas and new year fortnight this year compared with the same period last year. We talk about a 5% increase in the number of ED attendances at the front door and an increase in the number of 12-hour breaches from 205 to 334. The total number of patients coming to the front door of EDs increased by over 1,000, and the number of 12-hour breaches increased by just over 100.

You are right in highlighting the progress that has been made at the Royal. When Michael McBride and Charlotte were here last year, references were made to the difficulties that led to the establishment of the task group. That was over a year ago. A major incident was called at the Royal, the RQIA review followed that and so on. Since then, that organisation has made good progress, but it has taken time. The same organisation also had a difficult Christmas period last year. This year, in general, the trusts have managed very well through the Christmas period, albeit there have been challenging days, particularly, as Deborah said, the Saturday after new year. Accident and emergency attendances were 15% higher at Antrim than would be expected, 17% higher at Craigavon on a typical Saturday and 25% higher at the Ulster. We do not have the resources to run a system with sufficient headroom and tolerance to cope with spikes like that. We have no choice but to run hospital front doors and bed capacity closer to the wire than that.

Big spikes in demand are problematic for us. When that happens, our challenge and primary focus is to make sure that patients are kept safe and receive appropriately dignified and safe services. If, unfortunately, patients sometimes have to wait longer than 12 hours, as they did this winter, we seek to recover that position as quickly as possible. In the round, that is what happened over the last two weeks. Pat and I lead this work, working to the two chief executives, and we have never committed to having no 12-hour breaches this winter, given the time that it takes to effect change. We have sought to retain control and safety in the system. It is early days, but, so far, we have managed to do that.

The Chairperson (Ms Maeve McLaughlin): All of us can accept that there are issues with triggers and spikes in demand, but this is over a year.

Mr Sullivan: We can look at the figures over a number of years and at different times of the year. However, if we look at a whole year's worth of data —

The Chairperson (Ms Maeve McLaughlin): That is my point.

Mr Sullivan: Three or four years ago, there were 10,000 12-hour breaches.

The Chairperson (Ms Maeve McLaughlin): You said that you were not sure which statistics I was looking at: I am looking at the Department's statistics.

Mr Sullivan: I said that I was not sure which period they were for.

The Chairperson (Ms Maeve McLaughlin): I am looking at the Department's figures that were issued on 16 December 2015. They show that 288 people waited more than 12 hours for a bed compared with 125 people in November 2014.

Mr Sullivan: That is my point. You are comparing one month with another month. I am suggesting that we look at longer periods. The longer the trend, the more reliable it is.

The Chairperson (Ms Maeve McLaughlin): I am comparing this year with last year.

Mr Sullivan: No. You are looking at a single month in one year and a single month in another year. I am saying that, if I look at full years, I see that, three or four years ago, over 10,000 patients waited 12 hours or more, and, last year, 3,000 patients waited 12 hours or more. We are on target this year, plus or minus a bit, to be at the same level. That is not acceptable. Pat and I, and our colleagues, do not see that as acceptable, but we are making steady progress on where we need to get to.

The Chairperson (Ms Maeve McLaughlin): Are you saying that it is simply because there is more demand?

Mr Sullivan: Deborah and I are saying that part of the explanation is an increased level of demand in the system. There are more patients and patients with greater need, but we are not saying that we cannot address that. We are simply highlighting the length of time that it will take to turn the tanker around. The Royal has moved from a place where, two years ago, it had dozens of 12-hour breaches in a month to a place where it is now a once-in-a-blue-moon occasion. I believe that we can also get to the same place at the other sites, but it will just take a little time.

The Chairperson (Ms Maeve McLaughlin): There is, however, at this point, no improvement at the other sites.

Mr Sullivan: Improvement is not yet necessarily manifest in the 12-hour-breach position, but it is manifest in the level of understanding at a local level as to what needs to be done. I reassure the Committee that robust plans are in place, for this winter and beyond, to move to a sustainable place where we eliminate 12-hour breaches.

The Chairperson (Ms Maeve McLaughlin): On the other side of the system, there is a shortage of GPs, which is obviously impacting on our emergency departments. What is being done there?

Mrs McNeilly: The GP-led primary care working group is meeting fortnightly, with a view to putting a report to the Minister at the end of February. The number of GP trainees will be a key issue. That is actively being considered. We are keen to increase the number of GP trainees and for that to be considered as part of the overall 2016-17 Budget. We are also looking at relaunching a returner scheme. This year, we put in place additional support measures for GPs in the context of phlebotomists. Before Christmas, the Minister announced an investment of several million pounds to put pharmacists into GP practices. That was one of the first big things that GPs asked for when they came to the Department and told us what would help them.

An intense amount of work is going on in primary care, looking at GPs and skills mix and trying to bolster and build on that. The working group will report to the Minister by the end of February.

The Chairperson (Ms Maeve McLaughlin): If I heard you right, you said that you are keen to increase the number of training places for GPs: by how many and when?

Mrs McNeilly: The current number of trainee GPs is 65. There was a recommendation that that would increase by 15 initially and eventually get up to 111. That will be actively considered as part of the 2016-17 Budget process. If we are increasing the number of applications through the admissions process, we will align that to the timescale to make sure that we meet deadlines.

The Chairperson (Ms Maeve McLaughlin): Are we likely to see that increase of 15 places in 2016-17?

Mrs McNeilly: The Minister has yet to decide.

The Chairperson (Ms Maeve McLaughlin): Will it be in the considerations?

Mrs McNeilly: It is a clear recommendation for bids. The proposal will be put to the Minister, so it will be up to him to decide.

Mr McGimpsey: We increased the number of doctors in training some years ago. When Jim Wells was the Minister, I was amazed that he came here and told us that, in the previous year, you had lost 50 people who had graduated as young doctors and gone off to Australia and Canada. We are putting in an extra £600,000 per medical student for training, and, as you know, that money does not come from the Department of Education or anywhere else; it comes straight out of the Health budget. Money comes straight off the wards to pay for that, so you need some form of incentive or whatever it is you do to hold on to those doctors. We get reports that that process is speeding up rather than slowing down.

As you know, many GPs want to retire at the age of 60. Basically, they are not enjoying the work any more. The pressure is too much, and they have had enough. A large percentage of GPs are getting close to 60, so that is a major issue. That is an initiative on its own.

I listened to what you said, and I congratulate you on getting improvements. That is great. I always focus more on four-hour waits than on 12-hour waits because those are more crucial. Given the budget that you inherited over the past number of years, you are fighting a very difficult battle.

Julie, the main thing here is money. You get £4·88 billion: is that enough? We talk about under-delivery: will £4·8 billion give you enough to deliver? In other words, is it enough for things not to deteriorate and for the present position, with major backlogs, not to get any worse?

Ms Thompson: That is part of what we are working through at the moment in quantifying all the pressures and understanding the outworkings of £40 million going into elective care in this financial year and how that works through into next year. Until that work is finalised and we are clear about all the savings opportunities that supplement the Budget allocation, we will not know the answer to your question. We are focusing on getting all that quantified and bringing through all the opportunities to see where that leaves us. We are not far away from finishing that, but the work is not finalised. That will help to inform what we can and cannot do, which then works through into the commissioning plan direction, with targets and standards being set for the service. That work is being done to confirm where we can get to.

Mr McGimpsey: You have £4·88 billion. Where did that figure come from? You must have had an idea about what that would buy you. The question is about your projection of your need for that year. You will have a rough idea of what is needed to deliver that, so £4·88 billion was not just plucked out of the air. There must be a base somewhere. Things have been deteriorating over the past few years, waiting lists have been getting worse and so on. Will that £4·88 billion stabilise the situation so that you are dealing with backlogs, or will the deterioration continue?

Ms Thompson: The £4·88 billion allocation was agreed through the Executive process. You are right in that we know that pressures tend to be in the order of 5% to 6% from one year to the next; you will be familiar with that. We have a budget uplift of 2·7%, and the unknown bit is what we can bring to the table on further opportunities for reform and what that might look like. That work is ongoing, and it will help to inform how much we can do with the system and whether things can be stabilised and held as you describe. That is ongoing, and it will help to inform the commissioning plan direction. It has to be done in order to do that work.

Mr McGimpsey: When will you know that?

Ms Thompson: We will know within the next few weeks.

Mr McGimpsey: Will you tell the Committee as soon as you hear?

Ms Thompson: Yes. We will come back and update the Committee. We are happy to do so.

Mr McGimpsey: We need to know whether the £4·88 billion stabilises or whether you need a bit more money.

My second question is about backlogs. Talk to me about underperformance in the trusts. I do not mean trusts providing items of service for the money from commissioning but actual underperformance — for instance, when you buy 100 hip operations but you get only 80 and no money back. Talk to me a wee bit about that. All the trusts are underperforming, so it is about raising the level of performance in the trusts.

Mr Bloomfield: The trusts are under-delivering to differing degrees. As I mentioned, there is an improvement this year compared with last year. Given the wider context and challenges that the trusts are facing, improvement in the delivery of core elective activity, which is what we are now talking about, is largely as a result of efforts by the trusts and the processes that we have in place between the board and the trusts. As you outline, we have contracts with every trust in every specialty to deliver a certain number of outpatients, new outpatient appointments, review outpatient appointments, inpatient treatments, day-case treatments and so on. Those contracts were worked up in great detail in 2010-11 from the bottom up, based on the funded capacity of the system at the time. They are uplifted to reflect any investments in the intervening years. Those volumes are largely agreed between the board and the trusts. The trusts should deliver them, but it is clearly not as straightforward as that. It relies on a wide range of staff always being there, fully delivering the level of service that they are required to deliver, which, for varying reasons, is not always delivered. We see under-delivery of core volumes.

The situation varies between trusts, and it certainly varies between specialties. If you have a small specialty, for example, of three or four people, and one of them is off on long-term sick or maternity leave and cannot be replaced straight away simply because the trusts are unable to recruit someone with the right skills, you are losing 20% or 25% of your capacity. In a larger specialty with 10 or 12 consultants, it is easier, but it is not straightforward. It is not possible to look at the problem with a black-and-white view that you should deliver 100 procedures and you are not doing so; we need to be reasonable. The board engages with the trusts in detail on those discussions to understand the reasons for under-delivery and the make-up of the specialty and to look at the opportunities that the trusts have taken to recover that. We reach a view on the reasonableness of those efforts. In many cases, the reasons for under-delivery are understandable, the trusts have gone to great lengths to recover it, and there is very little that they can do. We will look at opportunities to provide assistance between the trusts. In other specialties, we have a view that they could do better.

The process that we have put in place over the last year, which I think is what you are asking me about, has secured improvement in specialties in which there has been continued material under-delivery of those core volumes. We have required the trusts to produce weekly improvement plans showing how many patients they need to see in order to hit their volumes and how many they plan to see, taking account of known leave, planned study leave, sick leave and so on, and to let us see improvement. We are looking for month-on-month, quarter-on-quarter improvement. As I say, it is still a challenge, but we are seeing the benefits.

Mr McGimpsey: I understand that, but is it not right that you still have a huge backlog?

Mr Bloomfield: Yes. There are two slightly different issues, but they are related. Part of the backlog can be attributed to the trusts not delivering their full volumes. Even if the trusts delivered their full volumes, it would not have been enough, over the past number of years, to maintain waiting lists, never mind improve them, because capacity exceeds demand.

Mr McGimpsey: What is the difference? Did you anticipate or ask trusts to deliver according to your requirements, but there was still a shortfall?

Mr Bloomfield: Based on the 2015-16 position, the current shortfall between funded capacity and demand — that changes year on year because demand has been going up year on year — is a capacity gap of 69,000 new outpatients and 36,000 inpatients and day cases. The order changes, but that gap has existed for a number of years. We have provided non-recurrent funding to the trusts for many years. If we look back over the last three to four years, from 2012-13, non-recurrent funding of £80 million to £90 million has been provided each year. That reduced in 2014-15. If you recall, a pause was put in place halfway through the year for patients who had been transferred to the independent sector. Until the additional funding of £40 million was allocated in November this year from the exceptional monitoring round, there was very little additional non-recurrent funding. Any additional non-recurrent funding this year up until November was all allocated to diagnostics, given the importance and urgency of diagnosing patients' conditions. We have seen the benefit of that in waiting times. The number of people waiting over nine weeks for a diagnostic appointment has been reducing steadily through this year.

On the other hand, largely as a result of the gap between demand and capacity that it was not able to fund, and partly because of the under-delivery of core capacity by the trusts, waiting times for assessment and treatment have increased. As I say, a huge amount of work is going on to maximise the effect of the injection of £40 million of additional funding in November and to secure as much

additional capacity as possible, both in-house in the trusts and in the independent sector, but that will be about halting the increase in the first half of this year and, indeed, last year. There is a capacity gap of 69,000 outpatients and 36,000 inpatient and day-case treatments that requires additional funding and has relied on non-recurrent funding for a number of years.

Mr McGimpsey: Do you think that £80 million to £90 million will fix that?

Mr Bloomfield: In previous years, £80 million to £90 million additional was the amount that was allocated. Over the last number of years, that has largely kept it steady as opposed to reducing the gap. All of us — certainly the Minister — recognise the importance of that. It is a priority for the Department, the board and the trusts not only to hold that at the current position — that is the first thing that we need to do — but to start to improve it. The £80 million to £90 million was needed to hold it at a standing position. It will take a greater amount of money to improve that position over a number of years.

Mr McGimpsey: Basically, the board places an order for so many procedures or services, and, if it does not get that figure, you folks move in and expect answers as to why the trusts are underperforming and why the times are slipping. It is called a commissioning process. Tell me this: who will do that, now that they are doing away with the board? I am sure, by the way, that the trusts are thrilled to see the back of you, but what will happen now?

Mrs McNeilly: The details on how the future model will be worked out will be done over the coming months. The Minister indicated, however, that some strategic planning for services will be done at a local level, and other services will be planned at a regional level. If we still require the support of the independent sector, we will have to commission services from it.

Mr McGimpsey: Who will do all this, Deborah? We cannot have each trust doing it; we are too small a country for five trusts to be doing their own thing.

Mrs McNeilly: The way in which commissioning was originally envisaged meant that trusts were to compete for business. However, Northern Ireland is too small for that.

Mr McGimpsey: It was to ensure that, when we spent the money, we got what we anticipated getting. As you have heard, there is underperformance, whereby the trusts get money for so many operations, but they do not provide what they are supposed to provide. Also, they do not send the money back.

Mrs McNeilly: The commissioning process was meant to have that competitive tension, but that is not how the system works. Northern Ireland is recognised — this was referred to — as being too small for that competitive tension. We do not have a marketplace for the independent sector to compete for some of this. The independent sector provides significant support in key specialties. In future, there will be an element of local planning and regional planning.

Mr McGimpsey: What you mean by local planning?

Mrs McNeilly: Some trusts will be able to plan some local services.

Mr McGimpsey: The trusts will do that.

Mrs McNeilly: Some trusts will be able to do that. However, the detail of all this has to be worked out and a blueprint made for the lower-level detail. This is about decluttering the process and working together. Indeed, some of the activity and our expectations on strategic planning for the trusts — what we expect them to deliver — will be done at departmental level. We will want to know what the trusts are going to deliver, and we will then put performance management arrangements in place.

Mr McGimpsey: Will the Department do that?

Mrs McNeilly: There will be an element of its reverting to the Department.

Mr McGimpsey: The best of luck with that. That is where we started: it was not working, which is why we made changes. That, however, is not my immediate concern.

Nurses in England, Scotland and Wales are all getting a 1% pay rise, but they are not getting it in Northern Ireland. How much would it cost, Julie, to give nurses 1%?

Mrs McNeilly: To give nurses 1% above their current pay rates would cost £20 million to £23 million. The trade unions put in a request, effectively, for 2%. They wanted to catch up with their Scottish colleagues, who got 1% last year. It was a request for 2%, so the cost would be well over £40 million.

Mr McGimpsey: Is £23 million the cost for 1%?

Mrs McNeilly: It is £20 million to £23 million.

Mr McGimpsey: It is £23 million. Thanks.

The Chairperson (Ms Maeve McLaughlin): To be clear: the 1% would cost £23 million. Where did the £38 million come from?

Mr McGimpsey: That is because nurses did not get it last year. It is the first time that you have broken the national agreement. It is a national agreement, and nurses nationally — in England, Scotland, Wales and Northern Ireland, because we are all part of the UK and it is the National Health Service — are all supposed to be getting the same rates, and you guys have broken it.

Mrs McNeilly: It was broken last year by England, which did not do the same as Scotland, and we did not do the same in Northern Ireland.

Mr McGimpsey: Northern Ireland went with England.

Mrs McNeilly: The national agreement was broken in 2014-15 by all the regions doing something slightly different. The larger figure is a result of the pay claim from the trade union side to give nurses the 1% that their colleagues in Scotland got last year and the 1% that their colleagues in Scotland got this year — 2%, effectively.

The Chairperson (Ms Maeve McLaughlin): One per cent is £23 million.

Mr McGimpsey: Nurses are doing better in Scotland than here, so, if you want a bit more money and you are a nurse, you go to Scotland.

Mrs McNeilly: The pay spines in Scotland are higher.

Mr McGimpsey: We have national pay deals in order to stop that.

Mrs Dobson: Thank you for your briefing. It is a massive understatement, especially from a patient perspective, to say that waiting times for elective care assessment treatments will be a challenge in 2016-17. Julie, you talked about substantial savings that you must identify across the system. The Chair touched on this, but where do you see those savings coming from in 2016-17?

Ms Thompson: That is the challenge — absolutely. We are looking right across the system. From a trust perspective — indeed from everywhere — you would look at back-office savings, leases, procurements, discretionary spend and so on. The challenge is that those areas have already been looked at, because we have been doing savings and efficiencies for quite some time. You would look at opportunities to reduce lengths of stay and to do things differently and better. Day-case procedures rather than inpatient treatment would produce savings. Reablement models are producing savings on the social care side, so you would look at that.

You would look further into all our arm's-length bodies, which have been asked to do scenario planning for savings. You would look into the Department's budgets and savings in prescribing budgets to see what could be done on how drugs are procured, which drugs should be provided, generic prescribing rates and so on. It covers a wide range of areas, but the problem gets more challenging year on year, because you are always adding on. You end up having to reform and transform how things are done, because you have already done work in a lot of areas, and you cannot make the same saving twice.

Mrs Dobson: It is certainly diverse. Is it doable?

Ms Thompson: That is what is being looked at. All the figure work is being done right across the system. There is a huge volume of work and ongoing engagement across the system to enable that to happen. The results will come through in the next few weeks, and that will help us to understand what is achievable and what the implications will be.

Mrs Dobson: Are you confident that we will know in the next few weeks and that it will not drag on from crisis to crisis?

Ms Thompson: That is the intention. We will keep things under review, keep iterating and so on, but we will have a much better handle on it than we have today. As we speak, it is a work in progress.

Mrs Dobson: I take it that you will be back before the end of —

Ms Thompson: I assume that I will be back to give an update to the Committee.

Mrs Dobson: In previous years, it has been a big concern to me that domiciliary care has been a chosen area for the trusts to cut back services. I realise that the whole service will be subject, as you outlined, to future financial pressures, but I am thinking of the domino effect: if you cut back on one, that will have an effect further down. What consideration is being given to issues like the effect of cutting back domiciliary care packages? I know that I am not the only MLA around this table who does a considerable amount of work to get that much-needed care package in place for people. There is an impact on the health of those who need a package but who do not receive the right level of care. What has been the thought process around short-term cuts with long-term consequences when you are considering the finances?

Ms Thompson: That is an absolutely valid point on how one thing can have a knock-on effect on another. Obviously, we are trying to meet client need for domiciliary care, and that need increases from one year to the next as people get older and have further and additional requirements; but that does not mean to say that we stand still. We need to look at how the services are provided —

Mrs Dobson: They do seem to be an easy target for a quick fix.

Ms Thompson: If you are in a situation where you have to get money out quickly, then, absolutely, they are something that you can turn down spend on, in the same way that you can turn down spend on elective care.

Mrs Dobson: But the need is getting greater out there with the ageing population.

Ms Thompson: Having said that, reforming the service, particularly through the likes of reablement and the services that can be put in place there, helps to get people back on their feet more quickly and ensures that they do not need a long-term package. This is all part of the agenda. Domiciliary care is a vital part of the service and can have a knock-on impact right back through the hospital system to emergency departments (EDs). On both sides, we are looking at how to get people out of hospital and into the right environment to meet their needs. We are also looking at people avoiding going into hospital in the first place.

Mrs Dobson: Allow me to take you back. You said that they are, effectively, a quick hit; a quick way of realising savings. Yet, there is an impact further down the line. How will we ever get ourselves into the position where we are not making those quick-hit decisions that have longer-term consequences, and where, to get money quick, domiciliary care services are hit? Can you envisage a time when we will be in the position where trusts are not taking that decision, which will affect some of our most vulnerable patients?

Ms Thompson: Certainly, in ongoing discussions and reviews of the area, they are looking at what we need to have in place on the ground for packages as people come through, as well as the nature of those packages and how those needs work out. However, it has to be done client by client and built up that way.

We are very alert to the need to avoid that negative impact as we look at plans and proposals to ensure — if people want to change a domiciliary care service — that the impact that change might have is taken into account. Again, you cannot say, "Well, we will do all our domiciliary care in the way that we have done it for —"

Mrs Dobson: They do need to be individually tailored, but I am talking about when they are being cut for a quick hit. People are not thinking of individual needs then. When they are set out, they need to be addressed to meet the patient's need. If it is a quick fix to get money —

Mr Sullivan: I think that the point Julie was making was that there is cash in domiciliary care which can be got at relatively straightforwardly in the way that it has been got at, unfortunately, in some previous years. To reassure members; through the process that Pat and I lead on, we avoid this happening by having sufficient clarity on wider objectives for patients and clients, and one of those wider objectives goes all the way back to where this conversation started today, which is ensuring effective patient flows through hospitals and so on.

Mrs Dobson: But, do objectives go out the window when you need to realise cash quickly?

Mr Sullivan: I hope that they will not, and I would not expect them to do so this year. I think that if we expect them to do so we are saying that all bets are off on what patient care looks like next year; and I cannot imagine any of us standing over that. So, the onus will be on the trusts. In the event of any trust bringing forward a proposal to do something different in domiciliary care, I, Pat and colleagues in the board, the Public Health Agency and the Department will be looking for clear assurances that its potential impact has been thought through, because it is a zero-sum game.

Flows through hospitals, all the way through to the decision to discharge, have been more effective this year than they were last year. The thing that has been more challenging than last year has been ensuring that there is an appropriate onward destination for patients, be it domiciliary care or wherever. So, the last thing we would do, with the amount of effort involved across the system in this work, is —

Mrs Dobson: We have all had constituents, including elderly people, who are spending longer in hospital because there is no package in place.

Mr Sullivan: Absolutely.

Mrs Dobson: The Chair touched on GPs earlier, as did Michael, and the domino effect. In my constituency, and I am sure it is the same for other MLAs in their areas, Craigavon Area Hospital took an unprecedented level of calls to the out-of-hours service, which seemed to have, effectively, ground to a halt. Again, the chief executive was very good at coming back to me constantly on the phone, but directors were trying to man the phones so that the service could cope. Constituents who contact you to say they have a sick baby and have been told that they will get a ring back in six hours have no choice but to go to an emergency department.

How are we ever going to get to the stage where that does not happen? It happens year in, year out. It was the Sunday before Christmas, and officials did say the situation was unprecedented; but we are getting used to hearing that. How do we get to the stage where that does not happen?

Mrs McNeilly: I spoke to the trust's chief executive and board colleagues about the pressures that the GP out-of-hours service has experienced. You will not be surprised to hear that there is a significant amount of work going on there. For example, they have brought in additional nurse triage and pharmacist support so that all the reliance is not on GPs. They are looking at accessing advanced nurse practitioners for triage, and they have secured support from Dalriada Urgent Care on taking calls and are exploring whether any further support can be provided there. To enhance and build capacity, they are also looking at whether remote triaging can be done by GPs. For example, GPs here can do remote triaging for the out-of-hours service in England, so why can we not do the same locally? That is being looked into. It has been agreed that a peer review of the operation of the out-of-hours service in the trust will be undertaken, with a view to it reporting back with any lessons that can be learned and actions that can be taken.

Mrs Dobson: Will there be lessons learned, Deborah? One of my constituents had a sick baby and was told, "Give them paracetemol, and we will ring you back in six hours." There was fear and panic,

and I said, "Get to the emergency department quickly". Paula, the chief executive, was great at constantly being on the phone to me. I was getting so many calls from people who were panicking about what they should do because they could not get out-of-hours callback. Are lessons being learned?

Mrs McNeilly: I do not have the figures, but a significant volume of calls to GP out-of-hours service are for repeat prescriptions. This week, I have asked that we look at why those calls are being made. Can we change the procedure? You used to be able to go into your pharmacist and ask, for example, for an extra inhaler, and you would get it.

The number of calls for prescriptions is significant — tens of thousands — and they made up a significant number of the requests during the Christmas period, which put pressure on the GP out-of-hours service. One of our options is to try to use the skills mix that we have in Northern Ireland plc, including our pharmacy colleagues, to take the pressure of those calls away from GPs, who are under pressure to triage medical conditions. That is ongoing.

Mrs Dobson: Is there an ongoing time frame?

Mrs McNeilly: I asked for it to be looked at this week; so, I would like to at least get a steer on the possibilities and options available.

We have talked about reform and transformation. Decisions may have been made in the past about doing things a certain way, and there may be impediments that I am not aware of. I want them to go back to the decision and see what we can do.
It is also about reducing the demand side. To increase clinical capacity, the trust has worked very hard in liaising with its GP colleagues to market this and by providing additional funding to offset the costs of indemnity, providing premia for working extra shifts and providing more flexibility, for example, by saying that people do not have to come in and do a four-hour shift but can come in and do a two-hour shift. It has been about doing an awful lot around that; and, again it is looking at remote triage. A lot has gone on in this space, and the trust is to provide me with an action plan by the end of February. It does have its ongoing actions, but I want to see some more specifics for assurance to us.

Mrs Dobson: For patients who are waiting, this is a service in crisis. People are suffering. They are waiting in pain, and a steady-as-she-goes budget will not fix it. We need a move in the right direction quickly because people are losing confidence, and they are getting very concerned and very worried.

Mr Sullivan: A couple of other things are relevant in this context. As Deborah said, an action plan is coming in at the end of February, and it is more of a medium-term action plan. As recently as this week, there were ongoing discussions between the board, the agency and the trust, as well as the Department, around the more immediate future. With the trust, we are exploring increasing the number of funded GP sessions. The demand issue, which Deborah flagged up, is one thing, and one of the central issues as well is filling the GP slots that are there despite the efforts being made to be more flexible with those slots. We are exploring with the trust whether, if we increase the number of GP slots over those that we, typically, seek to provide in the service, that might build confidence in the GP community to get the slots more routinely filled. Pat, Michael and I are also exploring at a regional level —

Mrs Dobson: Over the Christmas period, people cannot get to their GP.

Mr Sullivan: I mean almost with immediate effect though, Jo-Anne.

Mrs Dobson: The out-of-hours-service was simply not working.

Mr Sullivan: I guess that part of it might be because, if GPs feel that they are going to come into a service where there is only two or three out of four or five on, that in itself becomes a reason why they might not take up the opportunity to work in the out-of-hours-service. We are trying to work with the trust to build confidence through the mechanism I mentioned, and we are also exploring other opportunities. In addition to the peer review that Deborah talked about, we are exploring other opportunities to support the trust in identifying GPs to work in the service. I reassure members that it

is a very live issue for us, again for exactly the reasons that you are saying, especially for parents with kids. You might wait yourself for the next day —

Mrs Dobson: It is six hours before you get a call back.

Mr Sullivan: — but, if you have a child with a temperature, you are probably going to go to the ED in the absence of getting a reassuring call back from the out-of-hours-service.

Mrs Dobson: That is the advice that I am giving, because people are panicking.

This has been useful with the comparative of the hospital, but I would like to see more of this. I am thinking particularly of a question for written answer recently, and I will ask you to provide the details for me now. It was on the maximum time of 18 weeks for an appointment with a consultant. I have had a very alarming response showing that that has skyrocketed. Can you do more of this as regards appointments with consultants as well? I do not want to go through the figures because I know that we are focused on emergency care here, but the word "alarming" does not even come close. Can we have a comparison by hospital and trust? Each of these figures is a person and a family, and I think that we should never lose sight of the fact that there is a very human cost behind this. Can you provide that? I have figures for September.

Mrs McNeilly: Are they the elective care waiting time figures?

Mrs Dobson: No, they are the figures for people who are waiting longer than 18 weeks for a first appointment with a consultant. Craigavon jumped from 187 in 2013 to 8,752; so it is alarming.

Mr Bloomfield: There has been that steady rise from September last year.

Mrs Dobson: There were 187 three years ago, and it has risen to almost 9,000.

Mr Bloomfield: As of the end of November 2015, there were 119,000 people waiting over nine weeks, regionally. That is a rise from September 2014, when there was no more funding available for the additional activity that I was explaining earlier. There has been a steady rise. What I am pleased to be able to say is that the figure in October was 118,000 —

Mrs Dobson: It is the September details.

Mr Bloomfield: Yes, in September, there were 109,000 regionally. It had been going up by between 6,000 and 8,000 per month, over nine weeks, and similarly over 18 weeks, but, in October it went to 118,000, and in November it went up to 119,000. So we are starting to see —.

December will show a slight increase again, simply because there is some time where —

Mrs Dobson: Could you provide it —

Mr Bloomfield: Yes I can provide it.

Mrs Dobson: — because it is only through written questions that are we able to get this information.

Mr Bloomfield: With the addition of the £40 million allocated in November, we expect to see that the pace of increase seen over the past year will steady out.

Mrs Dobson: So, you are working to address this staggering rise with the —

Mr Bloomfield: With the amount of money and time available, it is about stopping the pace of increase, given the huge backlog that has occurred over the last year. Obviously, the work to bring that back down needs to be continued, but we can certainly provide the detail as broken down by the trust.

Mrs Dobson: If you could, because my figures are for September, through the written question, and "alarm" would not describe it. The rise is unbelievable, it has skyrocketed out of control. So, if you could provide an update, thank you.

Mr McKinney: I will take up the theme of domiciliary care. I appreciate that all of you, collectively, at the human level do not want to do anything to make it worse; but, unfortunately, the picture presented to me and to the wider public is concerning, especially against the backdrop of us originally recognising in 2011 that there would be a growing older population, and the fact that we should have done more about older people's needs.

In that context, can you explain how there are nearly 800 people waiting for domiciliary care packages? Some are in hospital because they cannot get a package, and some cannot get out of hospital because they cannot get a package. Around 230 have been waiting longer than two months. As well as all the issues around ED, we have people in hospital who do not have to be there. Let us explore, after this point, the further issues I have around failure in that area, or what I believe to be failure.

Mr Sullivan: I acknowledged in one of my earlier remarks that this is an issue. One of the challenges that the system and region has faced this winter, is those patients who have been identified as requiring domiciliary care support to allow them to be discharged home safely. There have been difficulties in identifying providers, particularly in some more rural areas, who are able to provide that support. That is one of the reasons.

Julie, I think you alluded to the fact that there has been a comprehensive review of domiciliary care with a view to understanding the current and future needs of our elderly population. That review recognises that those needs, as we all understand, are becoming more complex, and so the skill set of the domiciliary care worker required to respond to those needs is different than it would have been in the past. We need to look at this and at how those staff are trained, recognised and remunerated to safely and effectively discharge those roles.

The review also recognises that we can be better than we are at the minute in how and where we identify patient needs. There is a risk of identifying domiciliary care needs in a hospital setting before a patient has been discharged when, four or five weeks down the track, those needs may have evolved to be somewhat different. That creates the risk of over-provision or indeed, under-provision. So, all these things are being looked at and will, hopefully, bear fruit during this calendar year.

We find ourselves now, as you rightly highlight, in a place where there are very real challenges in securing domiciliary care packages for a number of patients, both those waiting in a hospital care bed or an intermediate care bed, and those waiting in a community for such a package, following a GP referral.

Mr McKinney: Less than a few weeks ago, the private sector said in a press release that health and social care trusts are placing the home care services, delivered by independent voluntary care sector providers, at risk by paying far less than the minimum cost to support people's basic care needs.

How is it that, for example, one trust pays one rate and another trust pays another? As I understand it, the average cost paid here is £11.35. The claim by the UK Homecare Association is for £16.16. The Western Trust pays £10.29, and other trusts pay rates above that. How is that happening?

Mrs McNeilly: Trusts go to the market and procure contracts themselves. Those are the contract prices that are negotiated during the procurement process. They go through the tenders they receive from the providers, but those are the rates.

Mr McKinney: Do they set a figure? Are you saying that the home care providers set it at that level themselves?

Mrs McNeilly: The providers have bid at certain rates of pay, and that is the subject of the procurement process. Their bids shows the rates at which they say they can provide the service.

Mr McKinney: Just to be clear on that point; the Western Trust will set a figure, and the provider will bid against that?

Mrs McNeilly: I am not sure if they set a specific figure or let the market tell them with, for sake of argument something like: here are all the bids, someone has put in a bid at £16 an hour, somebody else has put in a bid in at £10 an hour, and a different supplier has put in a bid at £14 an hour.

Mr McKinney: Why does the board not know that process?

Mrs McNeilly: The trusts do procurement directly. They will have a range in mind. I do not know if they tell providers to only come in at, say, £15. With the bidding processes that I normally see, you go to the market, you specify the service you need, and you ask providers to bid against that service specification. If service providers bid against that specification, then assessing those bids will be part of the procurement process.

Mr McKinney: But, we are finding that the private sector is saying that there is not enough money and that people are not getting paid enough. There will be a future pressure too, as regards the minimum wage. As I always say, that speaks for itself, in that we do not have a well-paid career here. Dean, you made reference to the need for properly trained and remunerated workers, and I welcome that. That is an important thing to say, and it should be converted into action. There was a key commitment in Transforming Your Care to establish a price regulator to allow for some, if you like, honesty in the debate, so that you do not have one trust undercutting another. What happened to that?

Mrs McNeilly: I do not have that brief with me, so I would have to check the position on that. I can come back to you on that issue.

Mr McKinney: Would you accept that some of these issues might go away in one aspect? They might not be resolved, but at least it would change the context of the debate if there was a price regulator.

Mr Sullivan: It may help. Trusts would be better placed to answer some of these queries. I know that with one particular organisation, it simply has not been possible for them — and I would not say at any price — to identify domiciliary care workers to work in certain areas.

Mr McKinney: But, given the comments earlier when we said that the market is not big enough to allow for competitive exchange, should the board not be setting a common standard for provision and a price attached to that?

Mrs McNeilly: The comments around commissioning were about trusts competing with one another in the market place. I think it said that some services would continue to be commissioned in the independent sector, which, in this spectrum, includes domiciliary care packages. So, there is still a market for domiciliary care. Going forward, it will be a matter of looking at the strengths, weaknesses and challenges facing that market and working out an overall strategy. The next stage will be how we stabilise and engage with that market. If I come forward, and there is a new tender by a trust for domiciliary care packages to start after the national minimum wage, I would be putting my prices up in the bid, and I would expect all the other bidders to do the same. As regards who bids for what, the market will differ, depending on the region in Northern Ireland.

Mr McKinney: Given the "brink of collapse" comments by the Care Quality Commission, and the threat they say exists to older people, and the fact that we have so many people in hospital without care packages, what does that say about our commitment to domiciliary care and the social care side of what we provide?

Mrs McNeilly: There are in the region of 24,000 domiciliary care packages being delivered on an ongoing basis, so it is a small fraction; but for those people, it is critical, and it is not right that they are sitting there. It is essential that they get their packages. I would not like to think that it is a huge number, in the context of 24,000; however, it is huge in terms of those individuals, and the trusts are working proactively on every one of those care packages. I know there are different challenges confronting trusts with rural areas, such as longer travel times, and providing support at different hours.

Mr McKinney: There is an economic downside too, because if people are not getting the less expensive social care side, they are then, very often, in the expensive hospital side, and it seems that some of them are there for months, at whatever the daily rate for a hospital bed is. Surely, that is a matter of urgency. I am not getting a sense of that.

Mrs McNeilly: Earlier, we discussed the possibility and perception that domiciliary care would be cut, going forward, and we gave our view that it is something that is important and that needs to be protected, because of the ripple effect. Again, I still believe that we should be looking at building

capacity there and underpinning it, because, as you rightly point out, the risk is that people will end up staying in hospital longer, which backs up to the ED. So, it is a whole-system approach. This is one part of the landscape that needs to be addressed, in the context of those 800 patients, but, more widely, for the sustainability of that service. The new service model and needs that the board has been looking at by way of the review have set the scene for how that will be taken forward.

Mr McKinney: I think I have said it many times, but I am dismayed, given that this was foreseen four years ago, that the work has not been done. You referenced a review document, Dean. Is that in the public domain?

Mr Sullivan: I referred to an ongoing review that the board is taking.

Mr McKinney: Can we see some of that?

Mr Sullivan: I am sure that there will be no difficulty with that when it is complete.

Mr McKinney: The budget stuff is tied in. According to paragraph 2, reform in transformation is top of the agenda. How much of the budget is dedicated to transformation?

Ms Thompson: That is still being looked at. The Minister said that he wants to create a transformation fund. In the work that we are doing at the moment, we are considering what that might look like across the spectrum. So, it will be a matter for the Minister to decide at an appropriate point in the process, but the decisions have not yet been taken. You will be looking at what needs to be looked at in the world of Transforming Your Care. It is not just that, however; it is much broader, whether it be about medicines management, ICT or any other service level reforms. It will be a matter for the Minister to consider, alongside all the pressures that are there, and then decide, out of that, how that gets looked at.

Mr McKinney: Given your earlier comments, there is not a lot. I appreciate that there are procedures and other ways of doing things but, in financial terms, from what you said earlier, there is not a lot of money there.

Ms Thompson: We have to fund it from the budget allocation and whatever else we can create from our own budgets. That is what we are working with. It will be for the Minister to determine how much he can make available for transformation. The key is that, as we look forward, we will need to transform and change, because we cannot continue to do everything that we are doing. An element of seed funding will be required to allow that to happen. We are absolutely committed to making that happen.

Mr McKinney: OK. Thank you very much.

Mr McCarthy: Much of what concerns me has been discussed, particularly through Fearghal's questions about domiciliary care, nursing home provision and the new minimum living age which is coming in on 1 April. People, particularly providers, have been saying to me that they are not going to be able to pay that money. Unless you people are on top of it before it comes, we are going to be in an even worse position than we are now. It has all been said, and I have heard all that has been said. I hope that you can do something to avoid a catastrophic position for elderly and vulnerable people.

Julie, you disappoint me, because, again, with all of this money, you still refer back to monitoring rounds. You know that last year, we were depending so much on the June monitoring round. I think you wanted £98 million —

Ms Thompson: Eighty-nine million pounds.

Mr McCarthy: — which you did not get. You got £40 million, I think, at the end of November. I do not know where that has gone to, but, over the recent period, there seems to be an issue with EDs. The Ulster Hospital, for instance, through no fault of its own, had to divert patients away because it simply could not cope. Why is that? Despite the money that you got for that very purpose, the trust had to endure the pain of having to divert patients to hospitals that could take them.

Ms Thompson: There are multiple issues, including the spikes and peaks in demand that Dean talked about. On the financial side, we will look at what we can do with the budget that we have. If we can get more assessments and treatments done through monitoring moneys, we will bid for that. Equally, we need to be clear about what we can deliver with the budget that we have, and we talked about the process to enable that to happen. However, looking into 2016-17, if we can get more money through a monitoring round that allows us to carry out more treatments, we will do that.

We have to maximise what we do with the budget that we have and ensure that as many people as possible are dealt with in the service. However, we will ask for more money during monitoring rounds to treat more people and get them through the system. That is not ideal, but, if the opportunity exists, we will take it. You are quite right: we got money in recent years through that process, which we were able to put to good use. Of the £47·6 million that we got in November, £40 million went to elective care. Much of the rest went to unscheduled care, which is providing many more treatments than would have been the case.

Mr McCarthy: During earlier visits to the Committee, you said that depending on monitoring rounds was not the best way to operate, yet you tell us that you still do so.

Ms Thompson: You could look at it another way: if we can access more money in monitoring rounds and treat more people, that is all to the good.

Mr McCarthy: It is not ideal.

Ms Thompson: No, it is not ideal. The more you know earlier, the better. We understand that.

Mr McCarthy: Exactly. If you can plan, you can do a bit better.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thanks very much for the presentation. The media reported that the number of people waiting for over 12 hours in an emergency department doubled, yet there was a reduction in that number in the RVH and the Mater. What happened there? What was done differently that meant that performance was better?

Mr Sullivan: We referred to the difficulties that the Royal had two years ago, when a major incident was called. Subsequent to that, the trust took forward a process of seeking to engage more effectively with clinical leaders across the organisation, involving them in the planning and design of care models. Out of that process, and working alongside professionals from Pat's organisation, colleagues in mine and, crucially, alongside the Belfast local commissioning group, new models of service were put in place that avoided the need for patients to be admitted.

We refer to those services as front-door ambulatory care services. They have taken some time to bear fruit, but they are now and have resulted in a reduction in the number of patients who would otherwise have been admitted to hospital. That reduction, combined with approved arrangements in the trust to manage patients who are managed through the hospital bed stock, has led to the position that we see coming into this winter.

As an adjunct to the services in the hospital, the trust, with the local commissioning group, put in place an Acute Care at Home service in the community. Almost before a patient even gets near the front door of the hospital, we try to care for them in their home to avoid an exacerbation of their condition, which would otherwise have required a visit to hospital and, more than likely, admission. Those two things, particularly the ambulatory care and other models at the front door, have been very effective.

Pat and I are working closely with other organisations to make sure that similar arrangements are in place to avoid, as far as possible, unnecessary admissions to hospital, and to care for people, as we refer to it, without their needing to put their pyjamas on. They just keep their clothes on and are cared for at the front door of the hospital. That, combined with keeping people safe in the community, has to be the answer to all this. We will never be able to provide enough hospital beds to respond to demand in a more traditional way. Belfast, through the leadership that has been shown there and the new models put in place, has shown what it has been able to do, having been in a very difficult position a couple of years ago. Similar progress is being made in different parts of Northern Ireland, where there are excellent models in place. There are other components of best practice as well. Pat and I are trying to pull all this together and make sure that, focusing on the big sites in the first instance, those key components of best practice are in place everywhere and seeing where that takes us.

Ms McCorley: What does "front-door ambulatory care" mean?

Mr Sullivan: I will have a go at explaining it in a non-clinical way, and maybe Pat will amplify that. In one set of circumstances, a person arrives at the front door of an ED with a combination of conditions that, in a more traditional model, would mean admission for a diagnostic test, as Michael talked about earlier, a period of review or even to see a specialist. In an ambulatory care model, rather than the default position being to admit patients on the same day or the day after, they are taken to a special ambulatory area, where they receive all the assessments that they require: the diagnostic tests and the specialist opinions that they need. In the vast majority of those cases, rather than patients being admitted, though that might still be the case very rarely, they are safe to go home with an onward care package.

Ms McCorley: Are they treated in the ambulance?

Mrs Pat Cullen (Public Health Agency): No. They are treated in an area that is close to the emergency department and has all the facilities that you would normally see in a hospital ward.

Ms McCorley: It is a treatment area?

Mrs Cullen: Yes. Patients are treated and kept there for a period of perhaps up to 24 hours because of the assessment and observation that they require from the trained staff in the unit. They are patients who may have cellulitis, a blood clot or other pathways that are not easily treated but do not necessarily require inpatient service. They can be treated in a facility that allows observation and treatment by the professional nurses and doctors who are easily accessed through that service.

Ms McCorley: Could these people arrive at the ED in their own transport or in an ambulance?

Mrs Cullen: They could.

Ms McCorley: Then, there is a filter system —

Mrs Pat Cullen: Yes. There is a triage.

Ms McCorley: Where does that take place?

Mrs Cullen: It takes place in the emergency department, and, after that, patients are moved. It works as one seamless service, right through.

Ms McCorley: Could those patients have to wait in a big queue in the ED to be referred to that ambulatory service?

Mrs McNeilly: It depends on the overall waiting times in the ED. If you need the ambulatory service, you will probably be seen more quickly than somebody waiting outside for an X-ray of a broken arm or something like that. You will get through more quickly. It depends on the clinical assessments.

The other thing about the Royal is that the emergency department moved to a new state-of-the-art building in August, which has helped. In that building, staff have been able to improve patient flow: patients come in via ambulance and go straight into the clinical assessment unit, resuscitation or whatever. With that improved flow, revised working procedures and pathways and clinical engagement, they have transformed the service that they provide. Now, if you arrive by ambulance, you are seen straightaway by a doctor, whereas, in the past, you might have been triaged and passed to a nurse. Please keep me right on this, Pat. Ambulance turnaround has also improved, saving a lot of time. Compared with earlier assessments, the conversion rates — the number of patients arriving and being admitted — have improved dramatically. Conversion rates range from 20% to 30%, and the Royal is now at the lower end of that scale. The procedures that have been put in place mean that fewer patients who go through the ED end up having to be admitted. That helps with the availability of beds and the overall patient flow through the hospital as well.

Ms McCorley: When people arrive at the ED, is the waiting time calculated from before they see anyone or once they have been seen by someone?

Mr Sullivan: It is calculated from the moment they arrive at registration.

Ms McCorley: Does that mean that they could be waiting for up to 12 hours before seeing anybody?

Mr Sullivan: No. The clock starts the moment they arrive and stops the moment they are discharged or admitted. Depending on the urgency of their condition, we expect them to be seen in seconds, minutes or, if the situation is not urgent, slightly longer.

Mr Bloomfield: The main delay is in patients being admitted. The waiting times are for people who arrive, are registered, triaged and then see a doctor or a nurse. Some get treatment and are discharged, and their waiting time is much shorter. The patients whom we are talking about — those who are delayed for 12 hours — are waiting for admission. Useful new information is available to the public on the website. It provides current waiting times in every emergency department — the average time from arrival until a patient sees a doctor or a nurse. That information is refreshed hourly and is available for everybody to see at any time.

Ms McCorley: What is the current average?

Mr Bloomfield: It varies, but from arrival and registration until someone sees a doctor or a nurse is typically around 45 minutes to an hour. The target, and the standard, is for people to be admitted to a ward or treated and discharged within four hours. For many who are seen, treated and discharged, the time is within four hours. Indeed, that also applies to many who are admitted. The main delay is people waiting to be admitted because of all the things that we have been talking about, particularly discharging patients. When you arrive and are registered, you are triaged very quickly after that. The most urgent patients are assessed at triage. Of course, those patients are attended to most quickly, but the average waiting times, which are now publicly available every day, are typically around 45 minutes to an hour.

Mrs McNeilly: The triage time slot is about 20 minutes from arrival to triage, so you should expect to be triaged within about 20 minutes. That is when your clinical assessment takes place and your risk is assessed, and that determines the next part of your journey.

The other point to make is on the decision to admit a patient. While patients are in the ED, they are being looked after and cared for. That is an important point to make because, when you read the stories in the paper, it sounds as though patients are waiting for 12 hours to be seen, but they are being cared for and treated in the ED.

Mrs Cullen: More recently, all the trusts have put particular emphasis on the care of patients who are waiting. It is by no means acceptable or ideal that a patient waits for a bed in an emergency department. That puts pressure on ED staff, and, equally, it is by no means a good experience for a patient. However, that is the situation that we are in.

We have been looking through the '10,000 Voices' feedback from patients, carers and staff about how we can provide the best care for patients who find themselves waiting in an emergency department. It is the simple things that patients really want when they have to wait. That means that there should be good communication — someone telling them why they are waiting and that they have not been forgotten. It means having a process in place to get them to a bed and that they are able to have refreshments and someone there to feed them. Our trusts have put all those things in place, with additional staff making sure that they are available and that patients have warm blankets and pillows. Patients kept telling us these things through feedback. A significant response from patients was that they need to feel that they are being cared for while they have to wait. Equally, the staff tell us that they feel more reassured that they are able to provide that care as well, even though it is by no means ideal.

Ms McCorley: What you are saying is that, when everything is taken into account, the main reason for long waiting times is that there are not enough beds.

Mrs McNeilly: They are waiting for a bed on a ward. Another action taken by the trusts is the setting of targets for earlier discharge so that decisions to discharge during the day are taken earlier. Typically, some of the pressures —

Ms McCorley: Why would a decision to discharge not be taken earlier?

Mrs McNeilly: Consultants make those decisions on their ward rounds. They decide which patients can go home on a given day.

Ms McCorley: Are there not enough doctors available?

Mrs McNeilly: If they are called away to, for example, unscheduled care pressures, they do not make their ward rounds so cannot discharge patients. A key priority for any trust is to get as many decisions to discharge taken earlier in the day. If, for whatever reason, decisions to discharge have not been made, as in many cases, you start to back up the system. There is work on targeting earlier decisions to discharge, and the trusts are actively pursuing that. However, there will be occasions when various consultants and doctors are not able to get round the wards because they have been called away or because of other pressures. That said, that is a particular priority for the trusts because it tends to be teatime when the pressure starts. The more people they can discharge earlier, the better.

The Chairperson (Ms Maeve McLaughlin): Surely emergency nurse practitioners can discharge and admit. Do we not just need more of them?

Mrs Cullen: They can. However, they work in the emergency departments; we are talking about the wards. There are other reasons for delay. We have to line up with families and carers at home to make sure that everything is set up for when elderly patients are sent home. The other issue that has come up time and time again is that most elderly patients discharged are on 10 or more medicines. It takes a bit of time to get those made up by the pharmacy and to explain the regime to the carers and patient.

The South Eastern Trust recently put in place a pilot to facilitate patients leaving wards, and that is working very well. A taxi service has been put in place to deliver medications, along with very good instructions on their use, to a patient's house as soon as they are made up. The trusts are looking to be innovative in every way that they can to discharge patients earlier, but in a safe way so that patients do not feel that they are being abandoned. Earlier discharge also means that they do not become a burden by taking up a bed. A number of trusts — probably all of them now — have discharge lounges for patients who are fit for discharge and ready to go. They leave the bed and are cared for in an area where nurses and healthcare assistants are available to support them until they have all their equipment and medication. They can also speak to relatives and wait in that safe until they leave the hospital.

Ms McCorley: Is that in operation at the moment?

Mrs Cullen: Yes, it is.

Ms McCorley: Has someone ever had to be readmitted because the follow-on resources were not in place?

Mrs Cullen: I beg your pardon. Do you mind saying that again?

Ms McCorley: Has a person ever been discharged and brought to that waiting area but had to be readmitted because their prescriptions had not been sorted out?

Mrs Cullen: I am not aware of anyone having to be readmitted from that area, but that is not to say that —

Ms McCorley: Has a blockage in the system caused that to happen?

Mrs Cullen: I am not aware of that, but that is not to say that it has not happened.

Ms McCorley: You talked about consultants discharging patients. What ways are you looking at to make that more efficient?

Mrs McNeilly: There is increased access to diagnostics, and timing is important. Some trusts are working directly with clinicians and monitoring how they do their rounds and how long it takes them. If there are particular pressures or they see a particular pressure coming — you can see pressures coming when you are planning — they will liaise directly with clinicians on the ground to identify

everybody who can be discharged that day. When there are particular pressure points, someone rings round the wards to see whether they can increase the number of discharges every day. There is constant monitoring of the situation, and the whole trust takes that on board in managing it. The senior management teams take that on board daily. They all monitor it very closely and try to redirect and reprioritise to keep it fluid.

Ms McCorley: You mentioned two ways to alleviate pressures on A&E. The second one was care at home. Will you tell me a bit more about how that works?

Mrs Cullen: It is operating very successfully in two of the trust areas, the Belfast Trust and the Southern Trust. You have probably seen some media coverage. What we describe as the Acute Care at Home service is for people who normally need an acute bed. These are people who would normally find themselves in an acute bed in a hospital, and it involves, in essence, operating a hospital bed at home. That requires community geriatricians, who are very experienced consultant medical staff, working with specialist nurses, occupational therapists and physiotherapists. The GP can refer directly to that Acute Care at Home team, and it will take over the care in a patient's acute illness phase for a period of up to seven days. The team will look after the patient, calling, on some occasions, up to six times a day, with a patient at home to ensure that the full service normally delivered in a hospital is delivered at home.

Ms McCorley: Is that more efficient, given that the teams are travelling around and calling on lots of people?

Mrs Cullen: It is the same team that calls in with the patient, so you may find that, initially, the consultant geriatrician, along with the nurse, physiotherapist and occupational therapist, will call and complete the assessment. The next calls could mostly be carried out by the nurse. The following day, more of the team will call in to reassess the patient. On the question of it being more efficient, it is certainly a better experience for patients, who tell us that they do not want to be moved. It is not good to move elderly patients out of their own environment. They become very confused.

Ms McCorley: I take that point.

Mrs Cullen: They lose contact with their family easily, and it is harder to get older patients back into their own environment again. It is certainly a much better experience for patients.

Ms McCorley: I take that point, but is it cost-effective?

Mrs Cullen: It is expensive, but it is certainly a better experience.

Ms McCorley: Is the recovery rate better?

Mrs McNeilly: If they come into hospital, there are issues about it being strange and then having to be resettled at home and being re-enabled to be at home. People can lose some independence and some of their functions if they go into hospital. There is also an increased risk of infection in hospital for elderly patients. Elderly patients who attend an ED can be more prone to infection and, if admitted, can end up staying in hospital. When you take into account what could happen after admission, you see that there is a preventative side to this model, and it also involves keeping the pressure out of an ED. I am not sure of the average length of stay of an elderly patient who goes into hospital, but it tends to be longer than the average of length of stay across the whole population, which is about five and a half days. We are doing the right thing for those patients.

Mr Sullivan: It is not cheaper than caring for them in hospital, but, undoubtedly, it is more cost-effective and entirely consistent with the transformation agenda that we have often talked about around this table. Why would we have an elderly person coming into hospital when for plus or minus about the same level of resource, we can care for them safely and appropriately in their home setting with all of the benefits that Deborah and Pat have talked about?

Mrs McNeilly: It achieves a better outcome for the patient.

Ms McCorley: What happened in Antrim to cause the big increase in its figures?

Mr Sullivan: It depends on what period we are talking about. Antrim has had particular challenges over the last couple of weeks. A number of reforms have been made there, and, not withstanding those reforms, it came under particular pressure on particular days. I talked about the pressures on a particular weekend, when it had 225 attendances, whereas, on a typical Saturday, it has 192. That is 17% more than is usually the case. The hospital had some challenges, therefore, with demand at the front door. Also, and this goes back to Fearghal's point, it had challenges in discharging patients who were waiting for domiciliary care, particularly to more rural parts in the north. However, no one at this end of the table is in any doubt as to the trust's commitment to addressing that. I know, having had a meeting with the chief executive in Linenhall Street this morning about the opportunities to reform discharge, that he is extremely focused on it and recognises fully that a whole system is needed. He recognises that, if he does not have the back door of the hospital or, indeed, all the intermediate care beds and so on working well, it will inevitably result in difficulties at the front door. There were challenges in Antrim on a few days. The challenges for us are to make sure that we respond appropriately to them, that patients are kept safe during that time, which they are, and that we recover the position as quickly as we can, which we have.

Ms McCorley: The domiciliary care package issue needs to be sorted.

Mr Sullivan: It does. It is an important one.

The Chairperson (Ms Maeve McLaughlin): OK, folks. Please just answer quickly, yes or no, to a few points that were raised. When will we see the commissioning plan?

Mrs McNeilly: Work is ongoing on the commissioning plan direction, and I expect to get to a very substantive draft — we always put final draft in inverted commas — towards the end of January or the beginning of February. I need to look at the rest of the timetable because engagement with Ministers —

The Chairperson (Ms Maeve McLaughlin): OK, and will that draft be shared with the Committee at that point?

Mrs McNeilly: As soon as we can.

The Chairperson (Ms Maeve McLaughlin): We were told that we would see a health economist approach to the care issue. Where is that at?

Mrs McNeilly: I will have to check for you.

The Chairperson (Ms Maeve McLaughlin): I will not open this up for debate, given the time, but that was one of the key messages. The Minister mentioned, when we were looking at domiciliary care and, then, at the Four Seasons crisis, that a health economist approach would be taken to the whole issue of care.

Mrs McNeilly: That is not my side of the house.

The Chairperson (Ms Maeve McLaughlin): Can we get an update on that?

Mrs McNeilly: Yes.

The Chairperson (Ms Maeve McLaughlin): Finally, it would cost £23 million for a 1% pay rise for nurses.

Mrs McNeilly: Yes, £20 million to £23 million.

The Chairperson (Ms Maeve McLaughlin): Will we see that in the 2016-17 health budget?

Ms Thompson: A decision has yet to be taken. That is the simplest way to describe the position. The pay award for 2015-16 has just been sorted out. We need to look into 2016-17 to see what that looks like.

The Chairperson (Ms Maeve McLaughlin): OK. Thank you for your time today, folks.