Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Breast Cancer Referral Rates: Belfast Health and Social Care Trust and DHSSPS

9 March 2016

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Fearghal McKinney
Mr Gary Middleton

Witnesses:

Mr Martin Dillon	Belfast Health and Social Care Trust
Ms Samantha Sloan	Belfast Health and Social Care Trust
Mrs Jennifer Welsh	Belfast Health and Social Care Trust
Mrs Deborah McNeilly	Department of Health, Social Services and Public Safety

The Chairperson (Ms Maeve McLaughlin): OK, folks, you are very welcome. We have — in no order — Deborah McNeilly, deputy secretary in the healthcare policy group in the Department; Martin Dillon, chief executive of the Belfast Trust; Mrs Jennifer Welsh, director of surgery and specialist services at the trust, and Samantha Sloan, clinical lead and consultant breast surgeon at the Belfast Trust. You are all very welcome. I invite you to make the presentation and then I will open it up for questions or comments.

Mr Martin Dillon (Belfast Health and Social Care Trust): Thank you, Chair. I have some opening remarks. First, thank you for the opportunity to discuss the urgent or red-flag breast cancer referral rates in the Belfast Trust. I want to start by bringing the Committee up to date with the current position in the trust.

Before that, I think it is very important for the Committee to note that 94·5% of patients with a breast cancer diagnosis receive their first definitive treatment within the maximum 62-day waiting time target. Also, I want to highlight that Northern Ireland has better clinical outcomes for patients with breast cancer when mortality rates per 100,000 population are compared to those in the rest of the UK.

In terms of bringing the Committee up to date; the current waiting time from receipt by the trust of an urgent or red-flag referral to the patient being seen at a one-stop clinic in the Belfast Trust is down to a maximum wait of 18 days, as of 7 March 2016. The benefit of having a one-stop clinic, which is a triple-assessment clinic, is that the majority of patients leave on the day with their diagnosis.

You will note, from the briefing provided to the Committee, that following Breast Cancer Awareness Month, in October 2015, and the launch of the Public Health Agency's breast cancer awareness

campaign the number of referrals into the trust increased from about 60 or 70 a week to between 80 and 100 per week. This continued for an unprecedented period of seven weeks. So, as a trust, we were receiving an extra 20 to 30 referrals per week. While, based on previous years, we usually see some rise in referral rates following awareness-raising campaigns, this year's increase in the rate of referral was 35% higher than it was in the years before. The increased referral rate, coupled with a pre-existing capacity shortfall, as well as consultant staff shortages, led to the drop in performance. From October to December 2015, the average wait was 18 days for those waiting longer than the 14-day target, and the maximum wait for any patient was 41 days. In previous years, any spike had been managed because annual capacity largely met demand. Therefore, smaller peaks or spikes in demand were effectively managed within resources.

Over the whole of the 2015 calendar year, the trust saw an 18% increase in referrals. In 2015, the trust managed a total of 2,759 urgent or red-flag breast cancer referrals. A total of 7·3% of those referrals, or 202 patients, were confirmed as having breast cancer. Of the patients who received a cancer diagnosis, 121 had not attended a one-stop clinic within the 14-day target. However, reassuringly, 112, or 92·5%, had commenced their first definitive treatment within the 62-day target. The remaining nine patients received their first definitive treatment in an average of 86 days.

The trust has very recently received funding for a fourth consultant breast surgeon and will commence a fourth one-stop clinic from 14 April 2016. This will give us the capacity to see a further 20 urgent or red-flag breast cancer referrals per week. The trust will also continue to run the additional evening clinics that we have run throughout March and April to manage the urgent or red-flag referral demand and meet the required waiting-time standard. Thank you, Chair.

The Chairperson (Ms Maeve McLaughlin): Thank you, Martin. You made reference to 14 April 2016. Is that the date for the additional funding to see the extra 20 referrals a week?

Mr Dillon: Indeed.

The Chairperson (Ms Maeve McLaughlin): The report talked about an investment of £876,000 to expand breast cancer surgery.

Mr Dillon: The additional clinic will start from 14 April 2016 —

The Chairperson (Ms Maeve McLaughlin): That money will be used for the additional clinic. What is the cut-off point? How long will the money last? How big a difference will it make?

Mrs Jennifer Welsh (Belfast Health and Social Care Trust): Perhaps I could pick up on that. The business case that was developed was for a range of things, including the one-stop shop, and we are delighted to say that that is recurrent funding into the trust. The fourth one-stop clinic will start on 14 April and will continue to run; it is not for a fixed period. That will enable us to permanently put that full clinic on.

The Chairperson (Ms Maeve McLaughlin): The funding for the fourth clinic will be recurrent. That will start on 14 April, and you have indicated that there will be 20 referrals a week to that.

Mrs Welsh: It will give us the capacity to see an additional 20 or 30 patients each week over and above those whom we are already seeing. It is to take us up to that level and peak.

The Chairperson (Ms Maeve McLaughlin): I am particularly interested in the fact that there is often a correlation between cancer rates and deprivation. I wonder whether you have an analysis of things like screening uptake, referral waiting times and survival rates in areas of need. Does the trust have an analysis of that or a view on that?

Mrs Welsh: We do not have that level of detail. We could seek that information from the Public Health Agency and share it with you. I would not expect a difference in referrals in, because they are done on a trust basis; but we can find out about the uptake of screening from different areas. I am not sure if Ms Sloan would like to comment from a clinical perspective.

Ms Samantha Sloan (Belfast Health and Social Care Trust): It is recognised in the eastern screening board area, which covers the South Eastern Trust and the Belfast Trust, that we have a lower uptake of screening in some of the more deprived areas. That is being dealt with through the

Public Health Agency, which holds the remit for screening, rather than the Belfast Trust. I understand that it is trying to invest in a programme on where it places its mobile units and how it tries to improve the uptake of screening in that population. It is also looking at the travelling community, because that is another risk issue.

The Chairperson (Ms Maeve McLaughlin): I will just go back to the initial point, Martin. Are you satisfied, or can you assure us, that the increased investment of the £876,000 in recurrent funding will take us out of some of the difficulties with delays in waiting times and red flag referrals? Will it solve the problem?

Mrs Welsh: Yes. We are confident that that will solve the problem, once we have all of the staff in place. At the moment, we still have vacancies. I am delighted to say that the clinical team will cover those vacancies until such times as we have some of the permanent appointments in place. Ms Sloan and some of her colleagues are making sure that we can run the fourth one-stop clinic, even though we still have one consultant vacancy.

The Chairperson (Ms Maeve McLaughlin): Were the delays in meeting the targets, previously, due to not having the staff in place?

Mrs Welsh: It was recognised that we did not have sufficient capacity to meet the demand, and the need for a further breast consultant and that extra clinic, as well as other theatre and operating times, and such things, to run the entire service were then recognised in the business case. So, it was recognised that that was what was needed to deliver the service fully.

The Chairperson (Ms Maeve McLaughlin): And this will address it?

Mrs Welsh: Yes.

Mrs Dobson: I am interested in the last line of your briefing paper, on breast cancer survival rates in Northern Ireland. It states that:

"if breast cancer is diagnosed and treated early (stages 1 and 2), 9 out of 10 women will survive."

That is, "if". It is deeply concerning when we see red-flag referral figures to the Belfast Trust sitting at 24% in December. Back in October, when I asked Mr Pengelly, at Committee, about the 14-day target, he responded by saying that the Northern Ireland target was largely being dragged down by performance in the Belfast Trust. Why then are we reading that, in November, it was 32% and 24% in December?

Ms Sloan: In October 2015, one of our senior members of staff was on long-term sick. So, we lost capacity of cover of clinics. We endeavoured to fill that gap with the use of a locum. However, one of our big issues with that timeline was that October was the public health breast cancer awareness campaign month. In one calendar month, our normal referral rate practice sees 200 referrals, potentially; but, in October alone, we received over 400. So, combining the almost double referral rate that we got —

Mrs Dobson: But you know that the awareness month is coming every year.

Ms Sloan: Not with the same peak that we got this year. Every trust has noted a huge, huge increase in peak, compared with what they managed before. We have seen it before — we can see that from our figures — and we put additional clinics in to cover that, but the demand was highly in excess of what we have previously seen. Combined with our staff issues —

Mrs Dobson: One member of staff left, so it all went —

Ms Sloan: It was a senior member of staff. We also have a staff grade shortage, and there is a change of job plan for another consultant into an academic commitment. So, multiple issues compacted at the same time.

Mrs Welsh: I should point out that this is a very small consultant team. The funding that we have been given to start the fourth clinic is related to the appointment of a fourth consultant. At that time,

there was funding for three, one of whom was off on long-term sick leave. It is a very small team; therefore, if a single member of that small consultant team is absent, it makes a significant difference. I take the point that the cancer awareness campaign happens every October. We planned for that, but the scale of the increase, this year, was not something that was expected by all the trusts. All of us experienced significantly higher referrals than we had envisaged, even with the awareness campaign.

Mrs Dobson: So, you will be prepared next year.

Mrs Welsh: Yes.

Mrs Dobson: Coming back to my questions to the permanent secretary, Mr Pengelly told me that the big issue was staff resources and that the Belfast Trust had secured additional resources. He went on to say:

> *"The Belfast Trust is now confident that, by October, it will be back to 100% compliance with the target."*

That was last October. We had 32% in November and 24% in December. Did anything else happen, apart from a surge in demand and a consultant being off? Jennifer, you have already said that you still have vacancies. It is a small team; one person is off. This is a matter of life and death, potentially, for these women.

Mrs Welsh: We were absolutely back on track. At the time when Mr Pengelly gave that message to you, that was correct. For example, our figure in September 2015 was 80%, and that had gone up from 50% in August. In October 2015, it was actually 99%. That was at the time when the cancer awareness campaign went off and we had that level of staff sickness. That meant that, in November, performance was only 32%. So, we were speaking with relative —

Mrs Dobson: And 24% in December.

Mrs Welsh: And 24% in December. That is correct. When we were giving that briefing to the permanent secretary earlier in the year, we had been confident that things were back on track. None of the trusts foresaw the level of demand experienced through the cancer awareness campaign, as well as the staff sickness. I think that we could have possibly managed with one or an element of those. With the combination of them all, there was a clear explanation of why we were dropping down to that low level, which we agree is not acceptable. Everyone has been working extremely hard to resolve that situation in as timely a way as we possibly could.

Mrs Dobson: Again, we have a campaign that encourages women to come forward, but when they do come forward, we see these appalling statistics. I am quite concerned that you say that there are still vacancies. So could we be in this situation again if another member of staff of that small team is sick? I know that you are talking about appointing a fourth consultant. It seems to be a recurring theme with the vacancies as well.

Mrs Welsh: I said earlier that the fourth one-stop clinic is starting on 14 April. That is even before we make that permanent appointment, because the remainder of the clinical team —

Mrs Dobson: Has that appointment been made yet?

Mrs Welsh: No. We had interviewed but, unfortunately, the individual took up a post elsewhere. We will be interviewing again to try to secure that post. In the meantime —

Mrs Dobson: Could that be delayed if you are unable to secure —

Mrs Welsh: No.

Ms Sloan: We have a commitment between our current clinical team that we are aiming to facilitate running the fourth clinic with a vacancy. We are looking at having very stringent lead management, overlapping responsibilities —

Mrs Dobson: But with a small team and a surge in demand —

Ms Sloan: Exactly. We have to work with what we have available. We do not currently have a consultant in that post, but the current clinical team is committed to trying to cover all the sessions and requirements that are needed to meet the demand as best we can. Over the last six or seven months, our team has been running additional clinics in the evening. So, you have to remember that that team has a daytime and evening commitment. They have agreed to continue with that commitment until we are happy that we are consistently meeting the demand and getting our figure back up to the 100% that we would like it to be.

Mrs Dobson: So they will be under increased pressure.

Ms Sloan: Exactly. That is —

Mrs Dobson: Let us hope nobody takes off sick.

Ms Sloan: Exactly. We have a small team that we work with. When we ran into some difficulties a few months before, at that stage, we utilised another trust to redirect some referrals —

Mrs Dobson: That is what I was going to ask you about: the South Eastern Trust.

Ms Sloan: — and look at it more as a regional service, rather than just as an individual trust-wide service. We were informed that referrals are at a GP's discretion and, therefore, the GP determines where the referrals will be centred. Our commitment is to deal with referrals received in our unit in a timely fashion.

Mrs Dobson: Is the South Eastern Trust still taking patients from Belfast to treat?

Ms Sloan: No.

Mrs Dobson: If you are not able to fill that post, given that the staff are already under pressure, will that start again?

Ms Sloan: At present, we feel that, because our figures have improved significantly, we do not need to go down that route, but if we feel that there is a significant drop-off in performance again, obviously, we will look at how we can address that. We do not want to adversely affect the patients that were referred to us.

Mrs Dobson: It is just deeply concerning that lives are potentially at risk because of this small team being unduly put under more pressure.

Mrs Welsh: I think that it is important to say, going back to the opening statements in Mr Dillon's statement, that we have had significant challenges at the 14-day part of the overall pathway. When we look at a 62-day pathway — this is the important bit — we see that it is about the time to treatment and not just the time to diagnosis. A 62-day pathway starts when a GP refers someone with a suspect breast cancer as an urgent or red-flag case. They would be seen and diagnosed at the initial one-stop clinic, and that would be confirmed and discussed at a multidisciplinary team meeting. There would be agreement on the treatment plan at that meeting and then with the patient, and the patient would go forward for their first definitive treatment. That has to happen in 62 days. The important figure is that 94·5% of all women are receiving that first definitive treatment within 62 days. I accept the challenges that we have had in the first 14 days of that 62-day pathway. Thankfully, even though some of them waited even longer than 14 days, 94·5% were seen and treated within the 62 days. That is the important bit. It is that first definitive treatment.

Mrs Dobson: I just hope that the Health Committee in the next mandate is not looking at figures like this for next year. Potentially, women will be dying while they are waiting if that is not addressed.

Mrs Welsh: I want to reiterate that we agree that those figures for the 14-day pathway are not acceptable, but the 62-day pathway to when someone is actually treated is an important one, and that is at 94·5%.

Mr McKinney: Thank you for your presentation. How long can you go on stretching the present staff in an attempt to deal with the problem in the absence of a longer-term solution?

Mrs Welsh: There is a range of things that we can do. For example, staff have given a commitment to keep this going. It is not just the consultant medical staff; we have associate specialists and others who can act up to a consultant position. We can also look at locum cover. There is a range of different mechanisms that we can put in place. Obviously, our preference is to make a permanent appointment to the post as soon as we can.

Mr McKinney: What stage are you at in that process?

Mrs Welsh: We interviewed on 22 February, and I would very much like to have said today that we had made a permanent appointment. We will go back out to ad again relatively soon, but I cannot give you a definitive date for that or for when we might make an appointment. It is more likely that we would be looking at a locum to support what we currently have in place.

Mr McKinney: Your attempt to get a full-time member of staff has not worked.

Ms Sloan: No.

Mr McKinney: What is the problem there? I do not want to go into the personal issues, but is there a problem there?

Mrs Welsh: No.

Mr McKinney: When you advertised the first time did you get a range of people —

Ms Sloan: We had one applicant.

Mr McKinney: So, what are the chances of you getting another applicant?

Mrs Welsh: Currently, probably slim, which is why I think that we will be looking at locum support.

Mr McKinney: It brings me back to my first point on how long this system can be stretched. I value the contribution that staff are making across the range, and I think that it is important the Committee recognises that. Once again, staff are putting their shoulders to the wheel against the system strain, but that is not acceptable. It should not be like that. The system should look after it. How long can that go on for, practically?

Mrs Welsh: I want us to explain what we have in post at the moment.

Ms Sloan: Currently, the Belfast Trust is funded for 4·5 whole-time equivalent consultants. Bearing in mind that we have a long-term sickness absentee, one of our associate specialists is acting into one of those consultant roles. We have a part-time consultant, who is shared with academia; me, as a whole-time consultant; and another whole-time consultant. In essence, we are currently running with 3·5 rather than 4·5. However, in addition, we have two specialty doctors and other supporting staff. Using that combined team, and based on our job plans and the fact that we have no other commitments outside breast surgery, we can cover the sessions in a fashion that we feel is safe. How long can we continue that? As long as we need to.

Mr McKinney: Incidentally, I would have preferred it if you had told us at the start that you had been unsuccessful rather than give the perception that you were in the process of getting somebody when, in fact, the process has ended and there is not somebody.

There is a disparity in the figures for the trusts as well. What is the explanation for that?

Mrs Deborah McNeilly (Department of Health, Social Services and Public Safety): Do you mean the individual trusts?

Mr McKinney: There is variation across the trusts. We had 11% of referrals seen on time in the Northern Trust and 24% in the Belfast Trust. We had an explanation for the Belfast Trust, but why the disparity? Then the South Eastern Trust is well down, even ahead of the campaign.

Mrs McNeilly: The issues are very similar to those in the other trusts. My colleagues referred to the very significant increase in demand, particularly as a result of the health promotion campaign. While actions were taken in all the trusts anticipating a spike in demand, they had not anticipated the spike in demand that we saw. Over the three months of September, October and November, just taking them as an example, there were 1,020 more referrals than in the same period the year before. Overall, in the year from April to January, there is nearly a 25% increase in the demand coming through. In the figures for February 2016, the position has dramatically improved across all the trusts. As a region, we are sitting at 99% in the provisional figures for February 2016 as regards patients seen within the 14-day pathway. In dealing with this, the measures that they have been taking are additional clinics and trying to take this through. I mentioned the figure of over 1,000 extra referrals in September, October, and November. That is approximately the equivalent of 68 additional clinics. That gives you an indication of the demand. The issues in the other trusts are very similar to what we have discussed today.

Mr McKinney: I notice, though, that the South Eastern Trust's figure dropped significantly in August, well ahead of any campaign. So what are the specific issues there?

Mrs McNeilly: My colleagues can keep me right, but we referred to the fact that, during June and July, as a region, the South Eastern Trust took over 90 patients from the Belfast Trust to help in managing the demand. That had a knock-on effect in its own performance in that period, but it was the right thing to do in managing the demand across the region.

Mr McKinney: Obviously headlines are headlines but to have it characterised as the worst-ever NHS performance is quite an indictment. I appreciate that you are stretching the staff and are looking for locums, but are there other answers to the question of how you can resolve this for the longer term?

Mrs Welsh: The thing that was very clear in the case of the Belfast Trust was a lack of capacity compared with the demands of what it was that we needed to see. That was recognised by the Health and Social Care Board and the Public Health Agency, and that is why they have made the investment. So, in order for us to make sure that we stay at 100%, it is important that the investment is recurrent, and, as you have heard, my clinical colleagues are content to keep this going. It is about recurrent investment, getting all of the right people in the posts, and making sure that the service is safe and sustainable.

Mr McKinney: I have one final point. Obviously, there is a big issue with the bank and agency system and locums because there is a premium and it encourages people not to take up permanent positions. Is there anything in this situation that relates to that dynamic?

Mr Dillon: Not in relation to this service.

Ms Sloan: From a clinical perspective, what we are seeing is not just specific to Northern Ireland. Across the UK, as a whole, there is a shortage of breast radiologists and breast surgeons. There are lots of units that are running with vacancies and finding it difficult to maintain and recruit staff. One of our problems is that we want to make sure that we are delivering a safe service and do not want to have someone in post who is not properly qualified or trained or able to deliver the service that needs to be provided. That is why we are very cautious about using locum provision at senior levels. We want to make sure that we have a good, robust service that will keep our patients safe.

Mrs Cameron: Thank you very much for being here today and for what we have heard so far. Most of the questions have been asked. However, on the back of what you just said, what is the reason for the shortage of breast clinicians across the whole of the UK? Is it because of the success of these campaigns? Are you surprised at the number of referrals that are coming through, and do you have any comment on what stage of cancer some of these patients are at?

Ms Sloan: Firstly, in our trust and across the region, I think that all the clinicians recognise that the number of referrals we are receiving are increasing year on year. Part of that is that ladies are more aware, due to breast awareness campaigns, that they should seek attention if they notice anything early. But, as you can see from our briefing paper, for the number of urgent/red-flag referrals, the

percentage of cancer diagnosis is only 7%. So, a lot of what is prioritised and seen as an urgent/red-flag referral is not cancer, but it is very hard for a patient to know that. We can know that once we have gone through the assessment and investigations.

Manpower is a bigger issue. There are problems with regard to recruitment into surgery as a sub-specialty. You will have seen UK-wide information on recruitment into specialist services and gaps in training and junior doctor provision. If we do not have the junior doctors going in to be trained, we will not have the senior doctors to run a consultant-delivered service. That is the thing that is specifically different about breast surgery: it is predominantly a consultant-delivered service. We have some advanced practitioners, nursing team associate specialists, who help to support our service, but it is predominantly a consultant-delivered service. That is a very different remit from some of the other specialties.

Mrs Cameron: It is difficult, especially in this day and age. Obviously, there is big pressure on GPs as well; maybe they are feeling duty-bound to refer just in case. They are afraid of someone slipping through the net.

Ms Sloan: As a region, we have 1,200 to 1,500 in situ or invasive cancers. Each individual GP may, at most, see one cancer in a year that is a true cancer, but they will see multiple ladies with breast concerns, be it breast pain, lumpiness, nipple discharge. They do not know — "Is this my one, or is this something else?". So, they will appropriately refer, as per the guidance that is there, for assessment. The referrals are all categorised and graded, and then dealt with. Thankfully, the majority of them turn out not to be cancer, but we still have to treat everybody as if they need to be assessed and seen.

Mrs Cameron: I presume that you, as a clinician, would rather see these women and give them the all-clear, than not have them referred to you.

Ms Sloan: Exactly. If you look at how the service is provided in Northern Ireland, you see that we currently have a triage system of 14-day urgent and routines. Mainland England has moved to 14 days regardless, but, obviously, that service had a high increase in investment and provision to allow trusts to deliver that. We are currently working on a 14-day target for urgent/red flags.

Mrs Cameron: I will just say, in finishing, that I am actually very impressed with what I am hearing. We hear so much bad news, but I am very impressed to see and hear how this situation has been dealt with. It is life or death for some, and it certainly puts my mind at ease to hear about the professionalism that is going on, the good work that is being done, and how you are all working together and across trusts to deal with these huge upsurges. I think that the PHA should be congratulated, too, for the success of the cancer campaigns. So, well done and thank you.

Mrs Welsh: Thank you.

Ms McCorley: Go raibh maith agat, a Cathaoirleach. Thanks for the presentation. The Belfast Trust has 60 to 70 referrals a week. Do you have the percentage for how many of those result in a diagnosis of cancer?

Ms Sloan: I am trying to work this out in my head. If there are 60 to 70 urgent/red-flag referrals per week, in a weekly clinic setting, we will probably diagnose between five and 10 cancers at most, and, in some weeks, we will not diagnose any cancers at all. There is a lot of fluctuation.

Mrs Welsh: Over the year, it works out at 7·3%. Of all the referrals coming in, 7·3% are confirmed cancers.

Mr Dillon: There were 2,759 urgent/red-flag referrals, and 202 patients were confirmed with a diagnosis of cancer.

Ms McCorley: OK. In the last paragraph of the report, it says that, while we are doing well as a region:

"we are still behind many European Countries".

Which are the best countries, and are they doing anything differently? What would be different?

Mrs Welsh: In the report that I have, it says that Northern Ireland has better clinical outcomes for patients with breast cancer, but that the UK, in general, is behind some of the other European countries.

Ms Sloan: Yes. Some of the Scandinavian countries have different screening programmes and different awareness campaigns. I think that the UK figures for Northern Ireland are very good, as a region within the whole.

Mrs Welsh: It is difficult to say. If the question is specifically on clinical outcomes for patients, yes, Northern Ireland does best out of the UK as a whole. Certainly, other countries have invested, as Ms Sloan said, in better screening programmes. There could be a range of factors in relation to, for example, access to cancer clinical trials, which may be higher in those countries than it might be here. It might be access to a cancer drugs fund. There is a wide range of factors in there that determine why another area would have better clinical outcomes.

Ms McCorley: Do you know which countries are at the top of the league?

Mrs Welsh: It is the Scandinavian countries.

Ms McCorley: Do you propose to look at what they are doing and improve on what we are doing?

Mrs Welsh: That is certainly something that the Health and Social Care Board and the Public Health Agency look at in how they commission services and the type of things that are needed for the entirety of Northern Ireland. The Belfast Trust then feeds into that process.

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

Mr Dillon: Chair, I beg your indulgence to say for the record — I think that the Committee has a sense of this — that we, in the trust, could not hope for a more committed, dedicated or compassionate breast care team. We are very much aware of the fact that we are talking about real women with real fears and real anxieties who want to know as early as possible whether or not they have cancer. We will leave no stone unturned in trying to improve our performance against the 14-day target. I hope that the Committee takes some reassurance from the fact that, as we have said, almost 95% of patients who are diagnosed with cancer commence their treatment within the 62-day target.

The Chairperson (Ms Maeve McLaughlin): Thank you. I think that we will take even more reassurance once we see the staffing issues resolved as well. Thank you for your time today.