Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Waiting Times for Elective Care: Department of Health

6 February 2020

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Sinéad Bradley
Ms Paula Bradshaw
Mr Gerry Carroll
Ms Jemma Dolan
Mr Alex Easton
Ms Órlaithí Flynn

Witnesses:

Ms Sharon Gallagher	Department of Health
Ms Lisa McWilliams	Health and Social Care Board

The Chairperson (Mr Gildernew): I welcome Ms Sharon Gallagher, deputy secretary for transformation, planning and performance, and Ms Lisa McWilliams, interim director for performance management and service improvement on the Health and Social Care Board. I invite the officials to brief the Committee, please.

Ms Sharon Gallagher (Department of Health): Good morning, Chair, and thank you for the opportunity to brief the Health Committee on waiting times for elective care. A short paper was provided in advance, which, I hope, was helpful. With the Committee's permission, I will outline some of the points in that paper as they are important.

It is regrettable that any patient has to wait longer than they should for a diagnosis, assessment or treatment. I fully understand the distress and anxiety that long waits cause, particularly when patients are suffering pain and discomfort. Waiting lists are seen as a measure of the state of the health service and are judged as an indicator of its performance. When they lengthen, that affects the public's confidence in the health service, as they are understandably concerned about being able to get the help they need when they need it.

The way in which services are structured is no longer fit for purpose, particularly as demand continues to increase year on year. Whilst in the few years up until 2015 additional non-recurrent funding allowed the position to be managed, a reduction in the amount of additional investment, coupled with workforce challenges, has seen the capacity gap grow since then; in other words, patients wait longer than they should.

Where patients' needs are deemed urgent or of the highest clinical priority, they will always be seen more quickly, but, inevitably, others will experience long waits. Over the past nine years, demand has risen by 9·3% for consultant-led outpatient services and by 2·4% for treatment. Regionally, in 2019, it is estimated, there is a gap between funded health service capacity and patient demand of approximately 35,000 new outpatient assessments and 41,000 inpatient day case treatments.

In a few weeks' time, I will be back before you to outline progress with the transformation agenda. This briefing is not unrelated, as waiting lists are, in many ways, a symptom of the need for change.

In December 2016, the Department launched its 10-year strategy for transforming health and social care: 'Delivering Together'. Underpinning that strategy, a plan to address the problems in elective care was published. Both documents recognised that long-term sustainability could not be achieved without dealing with the backlog. As a result, £30 million of transformation funding was allocated non-recurrently for waiting list activity in 2018-19, with a further £17·6 million this year. The funding allowed for 120,000 additional interventions in 2018-19 and will enable an anticipated 70,500 this year. However, it is important to say that that has served only to stem growth in waiting times. It is anticipated that a further £30 million will be invested in 2020-21 to help to manage urgent and red-flag referrals only.

Whilst non-recurrent funding is, of course, welcome and can benefit large numbers of patients, it is, as I outlined earlier, a short-term solution. It is imperative that new ways of working are introduced that will radically change the way services are accessed and delivered in the longer term. There is no point in continually doing more of the same. The elective care plan is still the road map for change. The pace of implementing the plan has been slower than we had hoped, given the scarcity of resource, but important progress has been made against all the stated commitments.

I mentioned the impact of non-recurrent funding on waiting times, and I will outline other key developments. A pain-specific section has gone live on the MyNI website to help people to self-manage painful and disabling illnesses. Capacity and capability in primary care have been expanded to allow more people to be seen or treated in the GP setting rather than being referred to hospitals. Multidisciplinary teams are now in place in five GP federation areas across the Province: one in each trust area. It is anticipated that, by the end of this financial year, 462,000 patients will have access to a primary care multidisciplinary team in their local GP practice. Not only does that ease pressure for GPs and allow patients to access more services closer to home but, in time, it will reduce referrals to secondary care. GPs can now seek advice from colleagues in secondary care electronically to manage patients locally. In addition, we have taken forward work that will modernise and reform secondary care. The introduction of the virtual fracture clinic, for example, has helped to reduce demand in fracture clinics by about 25%. Prototypes for day-case surgery, help for varicose veins and cataract procedures have been operational since December 2018 and are being evaluated. The evaluation will inform any future delivery models, which will be subject to consultation. Importantly, reviews in areas such as stroke, breast assessment and urgent and emergency care are ongoing to ensure that services are best configured to meet future demand.

Provisional information shows that, at the end of December 2019, over 110,000 people had been waiting longer than a year for the first outpatient assessment, and more than 27,000 were waiting over a year for surgery. That is wholly unacceptable, and the Executive have acknowledged that. It is anticipated that £30 million investment could be utilised locally to meet demand for urgent and red-flag cases in 2021. Additionally, 'New Decade, New Approach' sets out an ambitious target that states:

> *"No-one waiting over a year at 30 September 2019 for outpatient or inpatient assessment/treatment will still be on a waiting list by March 2021."*

The cost of delivering the additional activity necessary to ensure that that commitment is met is approximately £50 million. The funding available will be made clear in the Budget Bill, but I assure the Committee that work is already under way to ensure that any additional investment is fully utilised to best effect. Planning activity on red-flag and urgent cases has commenced with trusts. It is expected that that work will fully utilise any in-house or local independent sector (IS) capacity.

In relation to the 'New Decade, New Approach' commitment, additional capacity will be required from NHS and independent sector providers outside of Northern Ireland. Whilst firm steps cannot be taken to secure any additional capacity until the funding position is settled, the Health and Social Care Board is already scoping viable options. Every effort will be made to secure the additional capacity required elsewhere. However, it should be borne in mind that Northern Ireland is not unique in its waiting list position. Where capacity exists, it will be heavily sought after by multiple players. It is also important to

bear it in mind that there will be a cohort of patients who, due to co-morbidities or other factors, will not be suitable for transfer to other providers, particularly where travel is involved. Careful consideration will be afforded to how those patients are managed, but it may not be possible to meet their needs within available capacity locally.

In summary, addressing the waiting list backlog and reforming services to ensure future sustainability is complex and will take time. There is a long-term plan, but multi-year recurrent funding is required over and above what is needed to deliver core services. The required investment is estimated to be in the region of £750 million to £1 billion over a five- to 10-year period, depending on the capacity available. In the short term, I assure the Committee that all steps are being taken to ensure that any additional funds allocated for 2020-21 are maximised to deliver the best outcomes for patients. I am happy to take questions.

The Chairperson (Mr Gildernew): Thank you, Sharon. The paper quotes a requirement for £750 million to £1 billion additional resource. Can you break down for us how you arrived at that figure, how it would be spent and what outcomes it could deliver?

Ms Gallagher: I will ask Lisa to cover the breakdown of how we arrived at the figure. As for how it will be spent, it is based on two elements: dealing with the backlog — nearly as a ring-fenced entity — and delivering transformation. I set out those two aspects in my opening remarks. We cannot contaminate future models with the backlog. I use that word carefully because, if we continue just to do what we are doing with the backlog, we will not transform the way in which services are delivered and accessed. We already know that our structures are out of date. We need to completely transform our primary and secondary care services, and we need to enable people to look after their health better through the Making Life Better overarching strategy. It will be multiple measures, and it will be co-produced in terms of how we bring forward change. 'Delivering Together' sets out the broad premise of how that will be taken forward, but each of the steps and measures will be co-produced to make sure that we develop the right response for the people locally.

The Chairperson (Mr Gildernew): Can you provide the Committee with further detail in writing on the breakdown of those figures?

Ms Gallagher: I can, of course.

The Chairperson (Mr Gildernew): Thank you. Five years ago, the Committee flagged up the fact that there was a gap in the data and that a move from referral to treatment would be a much more realistic measure. Will the new Encompass system or integrated digital record enable tracking of the referral to treatment? Is it a specific aspect of the design brief for Encompass, or can it be added as a requirement?

Ms Gallagher: It will be able to measure that. Yes.

The Chairperson (Mr Gildernew): Finally from me, before I go to members, you mentioned very specifically that dealing with the figures would require the use of other NHS facilities and the independent sector. Are you exploring capacity in the Twenty-six Counties, especially where there are co-morbidities and where travel is an issue?

Ms Gallagher: We are indeed. Lisa and I were in Dublin earlier this week to discuss options with colleagues.

The Chairperson (Mr Gildernew): Is there potential progress there that you can tell us about?

Ms Gallagher: It is exploratory at this stage. As you will understand, Chair, they are in a challenging position also and have capacity and demand issues, but the conversation continues, and we have made a commitment to keep engaged with colleagues in the Republic of Ireland.

Mrs Cameron: Thank you for your presentation. It is obviously a huge issue, and there is no point in over-egging it. My question is based on the previous Committee for Health. At one stage, the Committee looked at coding and the issue of waiting lists and missed appointments and, in particular, hospitals cancelling appointments. From my very poor memory, I think that there were issues around how clinicians' leave was recorded and that type of thing. So, somebody would get an appointment, but the fact that clinicians were not going to be there was not factored in. That appointment either

moved to another clinician or the appointment was cancelled and put off to another time. That recording was not uniform around Northern Ireland. Has that issue been addressed? Do we have a more unified process of recording those details?

Ms Lisa McWilliams (Health and Social Care Board): I am happy to take that question. You are referring to the "did-not-attend" (DNA) and cancellation rates in hospitals. You are right that, at one time, there was a level of planned leave but at short notice, and with our clinic templates, patients would have already been booked six weeks in advance, and then we would have had clinicians booking leave. That practice has largely been eradicated. Where we do have cancellations, and there are still cancellations, they are largely due to sudden sickness, bereavement or childcare breakdown in clinical teams that cannot be avoided, or there are cancelled procedures due to theatres running over in more complex emergency procedures. Some of the cancellations are booked in error, but that is a very small level. That practice of short notice, planned leave has been very heavily scrutinised by the trusts' medical directors and has largely been eradicated.

Mrs Cameron: OK. Thank you. I have just one other thing to raise with you, but it has gone out of my head.

The Chairperson (Mr Gildernew): Do you want me to come back to you?

Mrs Cameron: Yes, please.

Mr Easton: Thank you for your presentation. Going back to the clinics being cancelled, extra resources is part of the reason that you need to try and move clinics forward and reduce the waiting lists, but that is not the only reason. We know so well that the issues are cancelled clinics, missed appointments and lack of nurses. There is a shortage of 2,000-odd. Obviously then, you have to use the independent sector providers, and that is costing more money because they are dearer. Do you not think that part of the problem has been caused by so many cancelled clinics? I am not blaming everybody in the health service for that, but even with the reasons that you gave for the reductions, we were told last week that there are still 200,000 clinics or something like that and hundreds of thousands of appointments being cancelled. This is building and building, and it is not because of the resource so much, although that is part of it. I know that because I used to work for the health service and I was very much involved in appointments.

You mentioned the 35,000 extra outpatient appointments that you need, but, surely, if we could cut those clinics down and get more people attending, you would not need the 35,000. What are you actually doing to reduce people's behaviours, such as not turning up?

Ms Gallagher: The first thing is that the percentage of DNAs and cannot-attends has reduced from 8·3% in 2015-16 to 7·8% in 2018-19. Partial booking, whereby people can book up to six weeks in advance, is, in the main, attributed to that. In addition, text messaging to remind people about their appointments has been introduced in some trusts. Media campaigns have highlighted the impact on others of cancelled or unattended appointments.

The other thing that I want to say is that missed appointments do not equate to downtime necessarily. Double-booking takes place to ensure that, when missed appointments happen, others can step in. In any case, clinicians are redeployed in other areas and can do other work when there is a missed appointment. It is not as though people not attending equates to downtime necessarily.

Mr Easton: Well, it does, because they get another appointment at a later date, so it adds to your lists.

Ms Gallagher: Indeed, although the double-booking means that someone else, who is taken from the list, gets seen in their place. That is the net position.

Mr Easton: Yes, but it still adds up down the road.

Ms McWilliams: Most clinics already build in a level of DNA based on their experiences in the past year and two years. Sharon has referred to that. We overbook clinic slots so that we actually take account of the do-not-attends. Our do-not-attend rates are comparable with those in England, Scotland and Wales.

Mr Easton: Am I allowed a second question?

The Chairperson (Mr Gildernew): Yes, go ahead.

Mr Easton: I have to change tack, because I have a second question.

You need £1 billion or £750 million for transformation of the health service in general. Do you have a figure for how much money you actually need to bring waiting lists down to level zero, if you know what I mean?

Ms McWilliams: We have an elective care plan, which was published in 2017. We repeatedly run the demand to capacity in the costing exercise for that. It was last updated at the end of 2019. The backlog of patients who were already breaching waiting times was costed, at that point in time, at £435 million. The capacity gap — just to address the gap in outpatients and treatments that we have referenced, in which we have incorporated a level of efficiency and productivity to take account of new ways of working in those numbers — sits at £96 million, but we acknowledge that that is an underestimate, because if we are not assessing patients, we are not transferring them or converting them for treatment. It is a minimum of £535 million just, at a point in time, to hold steady, but we have added patients to the waiting lists since that calculation was done.

Mrs Cameron: I want to come back to my first question on coding, because I do not think that you quite answered it. Is there consistency in coding in form-filling or electronic care records across Northern Ireland so that we have comparable data?

Ms McWilliams: We have policies that have been developed in the past number of years and updated to ensure that there was no ambiguity in our coding definitions and how they have been applied. That is a rolling programme. There has been significant realignment. There are areas outside elective care where we have done focused work on coding. There is an entire coding team in the Health and Social Care Board to support trusts and train coders in the trusts to ensure that everybody has standardised practice.

Mrs Cameron: Is that training ongoing?

Ms McWilliams: We continue to ensure that we have a sufficient coding workforce in trusts in order to ensure that information is coded in a timely manner.

Mrs Cameron: I had a wee question that I could not think of earlier. It was actually about communication, and it links to some of Alex's questions. You mentioned that some trusts have introduced text messaging; some, but not all of them. I know from personal experience that, in letters, text messages or other communications that come from the health service, some services will offer you the option to go online and book your appointment. That will obviously save a body at the other end and mean you are picking something that suits you, so that is positive. However, there never seems to be uniformity across the board, which is quite frustrating. I have certainly encountered communications about appointments that I am desperately waiting for still going to previous addresses after I have moved house. That has happened on several occasions in my household alone, despite the fact that, at every opportunity, we update and check. We say, "Look, do you have the right address?", yet it still seems to go astray. Are there any plans to make sure that those records are tight and kept really well so that that is not missed?

Ms McWilliams: The Northern Ireland Electronic Care Record (NIECR) and Encompass are both in that space to make sure that our systems are more connected and, in some cases, more automated so that, when you update an address in one specialty, it updates your record everywhere. Encompass and the Electronic Care Record are tools for that.

Mrs Cameron: OK. Could I ask just finally —?

The Chairperson (Mr Gildernew): Very quickly.

Mrs Cameron: Did we have the Electronic Care Record and now we are moving into Encompass, or is Encompass already live and running?

Ms McWilliams: No. Encompass will go live in the first trust next September and then roll out to each subsequent trust on a six-monthly basis.

Mrs Cameron: Obviously, the old Electronic Care Record will morph into that.

Ms McWilliams: It will feed into Encompass, yes.

Mr Carroll: Thanks for the presentation. I have a couple of quick points and questions. One of the figures that stuck out most for me in the last few months was the figure for Merseyside and Wirral. That trust is slightly bigger than all our trusts combined and there were 10 people on its waiting list for a year, whereas, here, it is 120,000; I think you said 115,000. It is quite remarkable that, in a trust almost the same size as all of ours combined, there are so few people on waiting lists. People here are 3,000 times more likely to be on a waiting list. That is obviously quite worrying on top of the figures that you have referenced. Alex's points about understaffing in nursing are key. He said 2,000; my understanding is that the health service is 3,000 nurses short. A comment on that, please.

Is there emergency planning or an emergency task force to deal with this crisis? I hope that that would be possible. Are any sort of conversations going on at ground level with trade unions and workplace representatives? If you went into a hospital and asked, "Can you help us to deal with these waiting lists rapidly?", I imagine that most people would be willing to offer a bit more if they could in overtime. I would like the detail of what is happening on the ground in hospitals and places like that to try to tackle this. Obviously recruitment is key, but retention is also key. Hopefully, the resolution of the pay parity issue will encourage more nurses and healthcare workers to stay here rather than go elsewhere.

The structural problems are also key. The significant withdrawal of funding that has affected the health service in the last 10 years has to be talked about. I do not think that it is talked about enough in respect of waiting lists. There has been a serious withdrawal of funds from the health service in the last 10 or 11 years, and that has to be addressed if we are to tackle this issue. It seems that we are always running to stay afloat and that there is a crisis around the corner every time.

Finally, in-house spending is key. I speak to people who are concerned that there is a strategy of slow privatisation of the health service; "Ship it out to the independent sector. Ship it out to the independent sector". It is my understanding — and I would like clarity on this — that pretty much every treatment can be done in-house. There may be one or two treatments for which there is currently no capacity within the NHS, but 95% of treatments can be done in-house within the NHS. Just some comments on those points, please.

Ms Gallagher: I will cover them in the order that I have written them down. You can remind me if —.

Mr Carroll: No problem. I know that there were lots of different things.

Ms Gallagher: First, my understanding is that the number of vacancies in nursing is in and around the 2,000 mark, but I will confirm that in writing to the Committee. When it comes to issues relating to staffing and the trade unions, the change agenda is very clearly based on co-production. We said that up front in our 'Delivering Together' strategy document. All the areas that we are taking forward comprise task and finish groups or collaborations that include staff, clinicians and those who work in services. We have recognised that the right decisions on delivery models and policy cannot be made in offices in the Department of Health, and we need to talk to the people who deliver our services. That is a firm commitment on any changes, including waiting lists, that we take forward.

On the issue of retention, the workforce strategy was one of the key documents that was developed, published and co-produced with the trade unions as a result of our Delivering Together strategy. There will be a number of work programmes that look at how we recruit but, more importantly, how we retain and empower staff to get the best out of them to do the job that they want to do.

On funding, no matter how much money is put into Health, it is just eaten up. It is on record that we could consume all of the block grant within the next number of years. That is why transformation is so important. We need to change the way that we do things, and transformation will take additional money on top of what is needed to deliver core services. I acknowledge your point about being nearly a bottomless pit for money, and that will remain so unless we completely and radically change the way we deliver services.

When it comes to in-house spending, our primary focus is to use in-house capacity. It is only when in-house capacity is completely exhausted, for any discipline, that we move outside of that. However, there are circumstances when that is needed. In particular, if we secure additional funding through the Budget for waiting list initiatives, we will need to look elsewhere, outside of in-house capacity or NHS capacity, in order to help us reduce the waiting lists for a period of time.

I think that covered all of your points.

Mr Carroll: May I just ask one quick question?

The Chairperson (Mr Gildernew): Very quickly, Gerry. You have had a fair crack.

Mr Carroll: I just want to return to the last point about looking for out-of-house services to tackle waiting lists. Will you go into more detail on that? There is a concern about doing that when there are facilities in the NHS and staff with the expertise.

Ms Gallagher: In relation to the 'New Decade, New Approach' target, our first port of call will be NHS in-house outside of Northern Ireland after we have exhausted everything locally. It is only after we have exhausted that route that we will move to independent sector providers. Once again, I would stress that our primary route is through in-house employees and only after that is exhausted do we move elsewhere.

Ms Bradshaw: Thank you, ladies. I just want to continue that a little bit. If I picked you up correctly there, you said that you will get the additional money, hopefully; you will exhaust in-house; you will, then, go to the independent sector outside Northern Ireland and then the independent sector —. Why would you do it in that order?

Ms Gallagher: There are two blocks of money, if you like, for waiting lists. There is continuing what we have done over the last number of years, which is dealing with the red flag and urgent cases. That deals with suspected cancer, where time is of the essence in those cases. That is why we would look at our in-house capacity locally for that and then our IS capacity locally for that. That is what that £30 million, hopefully ring-fenced to address those types of cases, is for.

The 'New Decade, New Approach' commitment is for the longest waiters. For that, we recognise that we will have exhausted all of our capacity in-house, and at IS level, for red flag and urgent cases. For the longest waiters, then, we will move outside of the Province for that. So, it is really about maximising everything that we have locally for our red flag and our urgent, and, even if we do that, we may not meet all of the demand in that area.

Ms Bradshaw: What discussions have you had with the independent sector about it being exhausted after that first £30 million?

Ms Gallagher: I will let Lisa address that point, but it is really based on our arrangements over previous years and our understanding of what is there at the minute.

Ms Bradshaw: You have not had a contemporary conversation with the independent sector?

Ms Gallagher: I will let Lisa talk a little bit to the detail on that.

Ms McWilliams: In the last two years, as Sharon indicated, we have targeted money at the red flag and urgent, so the most clinically urgent cases. In the first year, we were able to fully maximise a spend of just under £28 million, which was in-house and IS. This year, with our £17 million, only £5·4 million of that is currently IS spend. Sharon alluded to 2014-15, when we were spending maybe £50 million in the IS. It took time for the IS companies to build up that capacity, and it would be fair to say, with the amount of money that we have been spending in the IS, that that capacity will take time to regrow. There is always that balance, and it goes back to Gerry's point about maximising in-house and then the IS.

We are in the process of a new procurement system that the IS companies are all aware of. They are places of previous procurement that will pick up Northern Ireland IS, but the existing system is currently used in the Twenty-six Counties/ ROI, so all the providers know that we are working through that new contractual arrangement to allow the market to be tested, and the IS contracts come through

that. At this point, we have not had any direct conversations to ask any provider for their capacity, because we need to work through the steps of making sure that we maximise the in-house and do not risk losing across to the IS in that process.
Ms Bradshaw: That is fair enough.

I have a separate question. In a paper that we received separately, it is stated that 140,000 patients are waiting for a diagnostic test for the service. How much are you looking at using capital expenditure for procuring new diagnostic equipment? If you had more up-to-date equipment, you might be able to get things through quicker and more effectively.

Ms McWilliams: Absolutely. Within the costing of the £30 million for the red flag and urgent, £5 million is for diagnostics and about £3 million is for additional mobile CT and MRI equipment. That is a quick way of getting additional capacity that does not take six months of commissioning a new build and all of the work around that. We are absolutely looking at how we maximise, because diagnostics play a key role in getting patients through their pathways, and we do need to increase our capacity.

Ms S Bradley: Thank you for your presentation. My first point is on the overarching theme of standardisation. While I appreciate that reaching out to the independent sector is required and helpful in certain circumstances, there must be a full understanding of the point at which those patients are pulled back in for aftercare and whatever else is available to them, because the expense could very quickly run away, which obviously then detracts from being able to offer your own resource.

I want some clarification on the question that the Chair asked about Encompass. We were advised that, at one point, the Department's line was that the vast majority of the patient journey would be captured by Encompass and that the review meetings may not be there. I take your firm assurance that they will, but, to be clear, is that something that was recognised and corrected in the Encompass system or was the messaging that came out at one time that it was the vast majority and that it would be reliant on other systems incorrect at that time? There does appear to have been a change in that response.

Ms Gallagher: I will pick up on the question on Encompass, and maybe Lisa will cover the aftercare piece. Encompass has developed over time. It is a new system that is responsive to a new way of working. I am advised that, under any referral to treatment, there will be a target against which the full patient journey will be able to be measured. We will be able to measure that target in the way that you have described.

Ms S Bradley: In a way that is comparable with other areas? We are not able to compare now.

Ms Gallagher: Yes. We cannot do that at the minute, and we will be able to do it with Encompass.

Ms S Bradley: OK. The fact that we are measuring only new additions to pressures means that we are measuring the tip of the iceberg, as we are not always adding on the backlog of waiting times.

Ms McWilliams: I think, Sinéad, you are referring to planned and reviews?

Ms S Bradley: Yes.

Ms McWilliams: Currently, we are able to see review appointments and patients who are beyond their clinically indicated date of review, and we also track planned across a number of specialties. Largely, general surgery and scopes are for planned. We can already see that.

The referral for treatment, as defined in England, Scotland and Wales, does not take account of reviewed and planned; it stops at point of treatment. However, clearly, we are always looking at the totality of the requirement, which has to take account of planned and reviewed and making sure they are not waiting unduly. So, when Sharon referred to red flag and urgent, we have included, in the urgent category, people who have been waiting too long beyond their clinically indicated or planned dates. We consider that they are as urgent as a new urgent patient. We are already doing that. Referral to treatment probably excludes planned and reviewed, but it does not mean that we are not measuring it. We will continue to measure it and to make sure that we are bringing their waits down too. They are not currently captured in a ministerial target, but it is clearly important for the individual.

You asked a question about aftercare. When we contract with IS, we have a number of routes. When we contract with an IS provider, we have what is called "direct to send". That means that you are only being sent directly out for your treatment, and then you come back into the trust, or if you do not need any follow-up, you will not have any. The direct send does not have any aftercare in the IS.
On occasion, we send patients out for the totality of their requirement, so they are not bouncing backwards and forwards. They might get their assessment and treatment, and the contract will be very explicit about how many review appointments that individual gets in the IS, and it will be consistent with what they would get in HSC. It is the same pathway. Therefore, we try to minimise the ongoing tail of spend in IS, which maybe happened when we were spending money back in '15-16. At that time, people might have been followed up for several years, which is not the practice at this time.

Ms Dolan: This might seem like a stupid question, but the paper states that:

> *"insufficient capacity to discharge patients at times of increased pressure can have a material impact on elective admissions for treatment."*

Why is this? Is it due to a lack of home-care packages?

My second question is about the review of maternity and neonatal services that you mentioned. Do you have any more information on that, or is that something for further on down the line?

Ms Gallagher: I can follow up with additional information on maternity and neonatal services. I do not have any material on that today.

Ms Dolan: That would be great.

Ms Gallagher: The point that you make is not at all a stupid question. One of our key issues in health and social care is that, when people are medically fit to be discharged, they are not able to go to their own home or there is not access or capacity within the system. That is recognised as a significant issue for us. The chief nursing officer and the chief social worker for Northern Ireland are leading a group looking at delayed discharges in order to understand it better, to scope out the issue and to look for longer-term solutions.

Ms Flynn: Thanks very much for your presentation. I refer back to the Encompass programme that the Department is working on and some of the points that Pamela made about missed appointments, the do-not-attends (DNAs) and the could-not-attends (CNAs). Was any analysis of the DNAs and CNAs factored into the Encompass programme? For example, when the service framework for mental health came out, nothing was specified about the people who do not or cannot attend their appointments. With the backlog and the pressures on the waiting lists, can the Department identify a way to catch those people before they fall out of the system to bring them back in at a later stage? Was any of that factored into those discussions?

Ms McWilliams: I am happy to provide further information. I know that colleagues on the board who are responsible for mental health have been looking at that. Written reminders or text messages are not the best way to remind a cohort of individuals about an appointment or to communicate information. They are looking at getting the appropriate telephone numbers for family members or friends to do that, so there is a bit of work on it. Some of the traditional methods just do not work for cohorts of patients. I am happy to speak to colleagues who work in our social care directorate to get more information.

The Chairperson (Mr Gildernew): Will the new elective care plan set out more specific outcomes than the 2017 plan?

Ms Gallagher: Specific outcomes in terms of —?

The Chairperson (Mr Gildernew): Targets and how the waiting lists will be addressed.

Ms Gallagher: The elective care plan, in overarching terms, sets out where we will focus our energy. The plans that we referred to for any additional money will be absolutely clear about what we will buy or what we expect to deliver. There will be something more like an operational plan to say, "If we get £30 million, here's exactly what we will deliver or what we will get for that", in the same way as in previous years. There is a plan at an operational level to make sure that we remain on track and that

we get value for money. The overarching elective care plan sets out what areas we need to look at moving forward.

On Jemma's point about maternity services, you will revert to the Committee with those figures?
Ms Gallagher: We will.

The Chairperson (Mr Gildernew): OK. Thank you for coming along. We all share the view that the waiting lists are totally unacceptable. One of the reasons put forward is the growing and ageing population. Measures should be built into the system to plan for that, rather than using it as a reason. As well as exploring and maximising the in-house potential, there is a clear desire to see that being quickly developed and built, so that more can be managed in-house in the time ahead and we have a stable, well-resourced health service of our own, without going outside the areas. We will seek further updates on the emergency departments. For now, thank you for coming along today and for addressing the meeting.