Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Commissioning Direction for 2012-13

1 February 2012

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 Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Ms Pam Lewis
Ms Sue Ramsey

Witnesses:

Ms Catherine Daly	Department of Health, Social Services and Public Safety
Dr Andrew McCormick	Department of Health, Social Services and Public Safety
Mr Eugene Rooney	Department of Health, Social Services and Public Safety

The Chairperson: I welcome Eugene, Andrew and Catherine. For members' information, the commissioning plan has been tabled. It is not in your pack; it is on the table. The Committee Clerk has provided us with the commissioning plan direction for 2011, the direction for 2012-13, which was provided on Monday, as well as the priorities for action targets for 2010-11, so there are a few pieces that we can compare and contrast. Andrew, are you doing a presentation first?

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): Thank you for the chance to do this. It follows naturally on from the previous session because moving forward and setting a planning process for 2012-13 had to follow on from the completion of the 'Transforming Your Care' work. We are working to quite a tight timetable. I apologise for the fact that we did not get the document to you before Monday. We tried to but it did not quite work. It has not been finalised yet; it is a work in progress, although it is a well-advanced draft. We have made some significant changes, as will be clear from your comparisons with the other documents. I will say a little bit about why it is changing, what the underlying intentions are and give some reassurances as to the nature of the way in which priorities are being set and communicated in this document and more widely.

The technicality is that the commissioning plan direction is a requirement under the Health and Social Care (Reform) Act (Northern Ireland) 2009, which set the restructuring in place. The obligation in the Act is for the Health and Social Care Board (HSCB) to draw together a commissioning plan in line with the direction set by the Minister and to do that in agreement with the Public Health Agency (PHA). The underlying intention is that we will have a commissioning system, which has public health at the heart of it. Therefore, we are looking at what we called in slightly jargonistic terms in those days "end-to-end

commissioning". We are not just looking at commissioning of acute services. The temptation is to focus on that, but the intent is to fight against that process and fight against that tendency and to make sure that prevention, early intervention and all those principles are at the heart of the process. Hence, the strength of the Public Health Agency's role in the process, alongside the board as the lead organisation in commissioning.

It is intended to set out an overview of the nature of what is to be commissioned to make clear what is being commissioned from all the provider organisations. That is predominantly the trusts, although the discussion that we were just having about a commissioning of voluntary and community sector activities is also very relevant to the process. Therefore, that is the statutory reason for having the process.

The Minister wanted to do things a little bit sooner to have further progress at an earlier stage, but we are not quite on schedule, partly because of the need to draw together different strands of work. However, we are in a much better place than we were in the previous cycle when we engaged with you very late in the process just before the summer recess, which was far from ideal.
Part of the intent is also to move to a longer planning horizon. Therefore, we will look at three-year plans. There will always be an annual commissioning plan direction and an annual commissioning plan, but there will be a big improvement if we can develop more continuity and sustainability in the process.

We are trying to develop a whole systems plan approach that draws together the implementation of the Programme for Government from the Executive, our links into the economic strategy, which is increasingly important at the present time, and the investment strategy. We also have the Minister's priorities for health and social care, as he set them out in the statement on the 'Transforming Your Care' report on 13 December. We need to draw in and reflect the quality strategy and the work that is going on to review Investing for Health and produce a new public health strategy, as well as the not insignificant matter of having an effective savings plan. All those strands need to come together. The strategic programme boards that were mentioned earlier will address all those strands and then we will see the HSCB leading the work on the local plans. We have a clear distinction of roles, so that each organisation fulfils its statutory responsibilities in a very challenging context.

Moving on to the direction, we are putting a requirement on the service to demonstrate how the commissioning proposals that it presents will deliver on the Minister's priorities and how that will ensure equitable use of resources across different parts of Northern Ireland. That is where the capitation formula comes into the process. Therefore, demonstrating equity of resourcing is very important. We need to ensure that the board and the PHA improve the involvement of individuals, communities and the independent sector in the design, delivery and evaluation of services through strengthened local commissioning and effective performance management. So public and patient involvement and engagement is really important in the present context.

Finally, we need to look at how the board and agency fulfil their statutory responsibilities in the development of their commissioning proposals. There is a risk that we focus too much on targets, and we have had that discussion many times, not least with clinicians who sometimes say that all we care about are a few performance targets. I want to emphasise and take the opportunity to say that we have always sought to develop a balanced approach to giving a leadership message to the health and social care system, which places quality of service and patient safety first and foremost. The need for balanced financial planning is also important, as is the delivery of satisfactory standards of performance. So quality is at the heart of things. What the Minister is asking us to do — he started to ask us as soon as he took office last year, and he has asked a lot about it in developing the draft commissioning plan direction at the present time — is to try to introduce a much stronger focus on outcomes. That is absolutely right for what we are trying to deliver in health and social care.

The tendency has been to prioritise what can be measured and to prioritise aspects of process. Some of those are very important, and I think your constituents and the Minister's constituents will always ask questions about timely access to care, so we have not drawn back at all on having targets that are about timely access to elective care and emergency care. Those are genuine issues, but we are also trying to shift more of the emphasis to a focus on securing the outcomes that the population expects and away from process. That is an important aspect of it. We need to try to find a good balance and

ensure that we give attention to the experience of patients and clients in the service. That is why, if you compare the 2011-12 commissioning plan direction with the current draft, you will see that there is a reduction in the number of targets and an attempt to build up more outcome-based standards and targets in the process. The Minister has made it clear that he wants us to go further. There is a need to develop that. If we had data sets and information flows that matched more to outcomes at the present time, we would be doing more of that already. There is an investment in information gathering to shift some of the focus of that to make sure that we have the right helpful information to support the Minister's priorities.

Partly reflecting that, alongside the commissioning plan direction, we have a direction on indicators of performance. That is also provided for in the 2009 Act. The purpose of that is to make sure that there is a systematic gathering of information. It is not a new burden. The vast majority of that is already in place; it is just making it more systematic. The message is that we will be keeping an eye on a whole range of information. To make the right decisions to ensure effective management and oversight of services, it is important to have a very rich information base, so that you can then be sensitive to things changing. If one of the indicators of performance that is being monitored shows a sign of a particular problem, it is possible to increase the focus and management attention to it. That applies to anything that is in that direction. It is a very extensive list, but that reflects the fact that we have a very extensive range of services.

The other really important point that I want to emphasise is that, just because something is not specifically in the commissioning plan direction, that is not to say that it is not very important. Our message to the service is continuously that the function is to deliver the full range of services. There are some particular things that the Minister is focusing on at the present time, and that is part of why they are in the commissioning plan direction, but the responsibility is to provide the full range of services at high quality and full levels of safety. That is a general responsibility, and a lot of initiative and creativity is needed at each trust level and at individual service unit level. We need the enthusiasm, creativity and innovation of clinicians, social workers — every group of staff. That is what the service thrives on.

The strength of the health and social care system is the fact that we have individuals with initiative, and we want to promote and encourage that. That is not to say that the draft commissioning plan direction is a narrow straitjacket. On the contrary, it is designed to set priorities at a strategic level within which all functions can be fulfilled in the best possible way. The requirement is for the board and agency to respond to it once it is finalised. It has not been signed off and finalised. You asked to see it before it was finalised, and we have honoured that request. Time is quite short and we need to move forward with the next step of the process very quickly to let the plan be drawn up and, ideally, signed and approved before April begins. That is quite a tight timetable, but I am very glad of the chance to have this discussion now. I am sure that there will be comments and thoughts from you and members, Chair. I hope that was of some help in setting the scene.

The Chairperson: Thanks very much. The whole emphasis of the draft seems to be around acute services. The list refers to organ transplants, A&E, elective care and hospital readmissions. Paragraphs 3 and 4 cover public health, and there is a wee bit on allied health professionals. You are really picking out the areas that are not specifically focused on acute. We all recognise that the vast majority of healthcare is done outside the hospital setting, whether that is through primary care, allied health professionals or community care. To that end, if these are the ministerial priorities — I accept what you say that, just because they are not in here, does not mean that they are not important — the emphasis seems to be very much on acute. It seems to be top-heavy with things that are delivered in an acute setting.

Dr McCormick: Some of the acute sector targets depend on a whole system working. If we look at unplanned admissions, unnecessary hospital stays and patient discharge, we see that those, effectively, require better service delivery in the community sector, because that is what that will depend on. Minimising acute sector activity is part of what is intended. We then have targets for children, learning disability and mental health. There is an attempt to balance. I take your point, but a significant proportion of the targets and standards here are community sector orientated.

The Chairperson: I will give you an example. Jim, Mickey and I were at Dr Una Lynch's presentation that the Public Health Agency organised last Friday. Cuba changed the name of its department to the Department of Public Health, and it really shifted the whole notion of a service that was there to make you better to a service that was there to keep you well. The small change in language had a huge impact on mindsets. If you take that through to this document, the mindset is that we will concentrate on a healthcare system that will make you better. We want to see a healthcare system that will keep you well. The mindset in this document says one thing only. However, I do not want to dominate the meeting. Jim said that he wanted to speak. Other members can also come in.

Mr Wells: I am relieved that at least we are now trying to get the whole programme of the commissioning plan back into sync. Dare I ask when the commissioning plan for 2011-12 was formally signed off?

Dr McCormick: You never ask a question unless you know the answer. It was formally signed off very recently. It was formally finalised —

Mr Wells: One almost overtook the other.

Dr McCormick: Not quite; no. The circumstances in 2011-12 were particularly tricky with the election cycle and so on. We then had the first attempt at handling it through the proper process of commissioning plan direction and commissioning plan. So it was very much a learning experience. It was the autumn before it was formally signed off, but the truth is that the substance of planning was in progress well ahead of that. The system knew what it was trying to do soon after the election. We are in a much better place this time round, and that is because we also have the review in place to provide a very strong framework and background. However, I acknowledge your point.

Mr Wells: You do not expect us to be sitting here in February next year. You expect it to be considerably earlier.

Dr McCormick: Yes, that is our aspiration. It is even better to try to do work between now and the summer on planning for 2013-14 and 2014-15, and now is a good time to start that process. I accept what you say entirely.

Mr Wells: Some of your targets are extremely welcome. With regard to specialist drugs, you are saying that specialist therapies for rheumatoid arthritis sufferers should be commenced within three months by September 2012. That is extremely good news if it is delivered. You must be upping your expenditure on anti-TNFs and similar treatments to achieve that.

Dr McCormick: Again, the Minister made his position on that clear. He does not accept the long waiting times and is prepared to consider the reintroduction of a form of prescription charging to provide that funding. That is an explicit discussion that he has had and we are working hard to ensure that he has the right options to consider and the right process to deliver on what he wants there. A very significant financial challenge underlies that but one that has a potential, clear and specific answer.

Mr Wells: I love using this word but I found out only a few months ago what it meant: what you are saying is that there is potential for an administration or charge for prescriptions that will be hypothecated to buy drugs — than means ring-fenced, Gordon —

Mr Dunne: Is that what it is?

Mr Wells: It will be hypothecated to buy those specialist drugs —

The Chairperson: Can you spell it? *[Laughter.]*

Mr Wells: Are you kidding? It will be hypothecated to buy those specialist drugs to deliver a greatly enhanced treatment. It is wonderful that you are doing that. I have seen absolutely dramatic changes in people's lives as a result of those drugs. They are wonder drugs, and that is the only phrase to describe them. So that is how that will be financed?

Dr McCormick: Yes.

Mr Wells: That is significant. This is, perhaps, the first time that idea has been made so public.

Dr McCormick: Work was done on that before.

Mr Wells: I never saw it just as explicit.

You also have a target that 95% of patients attending type 1, 2 and 3 A&E departments are treated, discharged or admitted within four hours, and no patient attending any emergency department should wait longer than 12 hours. How does that tie in with the proposal under Compton that the number of A&Es will reduce? How will you achieve that target? Quite a few hospitals, notably Antrim and Dundonald, are failing quite miserably on the 12-hour target and other hospitals in the Southern Trust never exceed the four hours. How will you do that given the fact that you will be under much more stress with regard to providing A&E over a smaller number of units?

Dr McCormick: The best example to give in that context is around what has happened in Belfast following the temporary change that is now in place. The issue depends a lot on the deployment of staff, especially senior decision-makers. In Belfast, because the senior decision-makers are now more concentrated on fewer sites, the flow has improved. So there has been a significant improvement in the performance of the Belfast Trust. That is not new —

Ms S Ramsey: With respect, they have not improved in A&E.

Dr McCormick: Some of the statistics have improved around how they are measured in that there are fewer 12-hour breaches in Belfast. That has been demonstrated, and we can come back to you with details to substantiate that. However, there is a very significant challenge in a number of hospitals on that measure. A range of management, organisational and resourcing issues need to be handled in a very clear way. We had a discussion a short time ago about finding the right balance of access to A&E departments in the full sense, to minor injuries and out-of-hours. It is about getting the right balance of services so that they all work together and are used as effectively as possible.

I accept that this is very challenging but it is not the case that fewer means worse. On the contrary, in some cases, fewer can mean better. That is what Colm Donaghy said at the public meeting in September. Before the change took place, he expected and hoped that it would improve services, and the evidence shows that it has.

Mr Wells: Some of us met the Royal National Institute of Blind People (RNIB) before this meeting. I take your point: the fact that there is not a specific target in the commissioning plan does not mean that you do not regard a certain aspect of your work as not important. It was disappointed that there was no specific target on the Lucentis treatment for wet (age-related macular degeneration) AMD in Londonderry and Belfast.

That has been incredibly successful. It has been one of the Department's greatest successes in preventing age-related blindness. It has meant that people who would have been blind still have their sight. RNIB is a wee bit concerned that, having rolled that out, there is no specific target in the commissioning plan. Can we assume that the work that has started so well will continue?

Ms Catherine Daly (Department of Health, Social Services and Public Safety): Andrew mentioned earlier the fewer number of targets in the direction. We also have a direction on indicators of performance. Within those indicators, there are elements that were previously targets and are now included. We expect the trusts to continue to look at that. There is a specific indicator relating to AMD. I do not have that in my papers, but it is included in the indicators of performance. We expect trusts to look at that when they are analysing their performance. I want to pick up on what Andrew said; just because it is not included as a target does not take away from its importance. The focus is intended to be on outcomes.

Mr Wells: I suppose that the Department has shown a degree of honesty. You could have stuck that one in, confident that you would continue to be equally successful and that you would hit targets. Perhaps it is not as stretching as others, but it will confirm that you are definitely going to continue with a programme that was rolled out only 18 months ago. I know that it has revolutionised the lives of people in my constituency. It is extraordinary what those drugs can do. I am relieved to hear that, although it is not specifically referred to, the programme will continue. People are also very concerned about waiting times for first appointments for people who have been diagnosed with an eye condition and who are then reappraised. I declare an interest because my daughter is in that position. Equally, I am also chair of the all-party group on visual impairment, and the stats seem to be drifting in the wrong direction. Eye conditions can deteriorate while people are waiting. Is there any update on that situation?

Ms Daly: I do not think that that issue is specifically included in this. We can look at that.

Dr McCormick: We will come back to you with the information that we have on that.

Mr Wells: Finally, when are the x's going to become figures? I see, for instance, that target 13 relating to healthcare-acquired infections is:

"By March 2013, secure a reduction of x% in MRSA and Clostridium difficile infections"

I am keen to know what the x% is.

Dr McCormick: Yes. We want to finalise the whole thing very soon, so that has to be completed quickly. We will communicate that to the Committee as soon as we possibly can.

Mr Wells: Equally, target 18, relating to long-term conditions, has a double x.

Ms Daly: As Andrew said, it is a work in progress. It is unfortunate that some of those targets contain x's, but we are working on that.

Mr Eugene Rooney (Department of Health, Social Services and Public Safety): There are two x's, and you have highlighted both of them. The telemonitoring contract came into operation in December 2011, and we want to establish a challenging target for the first year of delivery. That is being put in place at present; we were not in a position to put a figure on it at this stage. There is some analysis under way at the moment of the MRSA and clostridium difficile data. As Andrew said, we will come back to you straight away as soon as we have an appropriate figure for the coming year.

Mr Wells: Finally, I am quite surprised; some of those targets are very demanding, yet it has been a real battle to get the budgets to balance. You have done that. It is to your credit that you have managed to find the money to balance the books at the end of this financial year. However, you are starting all over again and you are expected to find roughly another £200 million.

Dr McCormick: Yes.

Mr Wells: It is difficult to understand how you can stretch to those targets and find that £200 million. As I said to John Compton, there is definitely a knighthood for someone if they can achieve that. How is it possible to spin both plates and come within budget, having already eaten out a lot of the fat in year one, and yet put up a series of targets that would be difficult to achieve normally never mind when you are also trying to find so much money in savings?

Dr McCormick: We are very well aware of the challenge. In my conversations with John in the Health and Social Care Board and with the trusts, we have acknowledged that this is the most challenging conjunction of circumstances that we have ever faced. Last year, I expressed a concern during an evidence session with this Committee that we balanced the books partly at the expense of some of the standards of performance.

There is by no means a simple trade-off, but there is an element of interaction with those issues. For example, if we had more money to spend in 2011-12, we could have secured more elective care, and

the waiting times on some aspects of elective care would therefore not be as challenging as they are at present.

There are still some significant decisions to be taken in relation to the financial balance for 2012-13. Further discussions will also take place. I have a meeting with the board tomorrow, and the board has meetings with the trusts tomorrow on that very issue. We will then engage in putting further advice to the Minister on how to finalise the financial plan and fulfil the obligation that is on all Departments, as Minister Wilson said, to publish savings plans. We need to finish that process, get that sorted out and draw out the implications. There are still some difficult decisions to be taken at all levels in the process.

Part of what we are saying in this process is that there needs to be a statement of standards and targets. In some cases, that is a big stretch, and in some cases, it is about saying that a standard is acceptable only if it is close to that target. Even if it is not being reached, it is still a statement that says, "This is what should be achieved". We then need to work with the service to do the best possible work to get as close as possible. In some cases, the targets will not be met. We know that, and, in a way, we are setting up an issue that means that the service will face some challenges. However, that is only an honest expression of public expectation.

None of us would be happy to wait for 12 hours in A&E or to wait for a year to access elective care, yet we know that individuals are facing those challenges at the moment. From my point of view, that is not acceptable. We have to work with the service to find the best possible ways to solve those issues, and that will include service reform. Lots of things can be done to empower clinicians and front line staff to work in smarter ways. Sorry, I did not put that carefully; there are ways that they can suggest and innovate that will improve the way in which things are done and take away some of the duplication of processes that can cause avoidable delay. Therefore, we need to release the innovation and creativity of the service to maximise it and get the best for patients. That means recognising respect for a clinical judgement as to what matters while also saying that there is public accountability for standards.

It is a complex range of issues. Not all the targets will be met. I need to be very direct with you on that point. However, the service will do its very best to get as close as possible. It is right for the Minister to set standards and targets that represent public expectations. That is partly why your view is so important at present. If some of those standards and targets are more or less than you would accept, we need to know about that and advise the Minister of the consequences.

Mr Dunne: I welcome the panel here today. I take it that the targets are compliant with the Compton review?

Dr McCormick: Yes, and some are specifically to deliver 'Transforming Your Care'.

Mr Dunne: So, they have been set up with the Compton review in mind. I take it that the ministerial priorities are running in order of priority? I take it that the plan is set against ministerial priorities?

Dr McCormick: Yes, the direction of change that you will see from one year to the next is our response to what the Minister is asking us to do. He is asking us to have a much stronger focus on outcomes, to have fewer but more focused targets and standards, and for that to be supported by this process.

Mr Dunne: The direction mentions screening for bowel cancer, which is quite a high-risk area. The target is that 50% of men and women are to be invited to attend the bowel screening programme. Should the target not be to screen 50% of men and women rather than just invite them? I feel that the word "invited" is vague compared with aiming to have the process carried out.

Dr McCormick: The underlying purpose is to ensure that everybody is screened over a two-year cycle. That is the intent. We recognise that the process involves inviting people to come for screening, but this is something that absolutely needs to be encouraged and promoted. That is why awareness is important. This morning, I was sitting near a prominent poster stating the death rate from bowel cancer in the UK, where it is a substantial issue. A combination of interventions is required at primary care level. So, GPs should encourage people to respond to the invitation, but the objective is to

ensure that it happens and that people are aware of the issues and risks and that we now have a very effective screening programme.

The Chairperson: Andrew, I think that Gordon's point was that the target is that 50% of the target group will be invited in. If only 70% of those people turn up, we are talking about only 35% of the population. So, you would want to invite 100% with the aim of getting 80% or 90% to attend. The wording is too fluffy.

Mr Dunne: Your will get quite a fallout from that 50%. Your big issue will be people who do not present and do not keep appointments. To me, an invite suggests that there will be a letter in the post, and that will be as far as it goes. So, is your target to send a letter to 50% of the people?

Dr McCormick: I see. It is easy to do that. Sending out letters is easy. The objective is to secure the screening, so I am happy to change that.

The Chairperson: Gordon is making the point that what you are saying is that you are doing the easy part.

Dr McCormick: I hear what you are saying. Let us change that. Again, the target is 50% one year and 50% the next, so 100% would be invited over two years. Again, that is only invitations. We need to look at that carefully. I think that we should change that.

The Chairperson: Yes.

Mr Dunne: I take it that it is the Minister's number one issue; is that right?

Dr McCormick: I do not think that the targets are in priority order as such.

Mr Dunne: They are not in any order. OK.

Dr McCormick: The document attempts to put public health issues up front and work through a logical sequence. That may be where there seems to be a risk of an apparent imbalance. So, again, let us look at how we present that.

Ms Daly: Certainly, the intention of that target is to secure 100% screening over the two years, but we can look at changing the wording.

Mr Rooney: It is certainly about much more than sending letters of invitation. It is quite a challenging target to have 50% screened in a year, but we will look carefully at the way in which it is worded.

Dr McCormick: Thanks for that point.

Mr Dunne: OK. Thank you. Will public health targets include addressing the issue of alcohol abuse and educating young people in particular about it?

Dr McCormick: There is no question but that alcohol will be a significant element of the new public health strategic framework. Colleagues will be aware of the conference with the South last week on alcohol issues, and the Minister has made several important announcements in that area. It is a very significant part of the strategy. As a public health issue, it is a very significant demand. The new strategic direction has been in place for some time, but further work is ongoing, and it is a policy that is always worth refreshing and reviewing. We are looking very carefully at what is happening in Scotland on minimum pricing. I was with colleagues there who are trying to take forward legislation on that. So there are lots of dimensions to that, but, yes, it is a very significant element of the strategy.

Mr Dunne: I want to make a point about cancer care services. The target is for 95% of patients urgently referred with suspected cancer to receive their first definitive treatment within 62 days — two months. That seems like a long time. Perhaps it is not, but from a layperson's perspective, it seems like it is. If someone is suspected of having cancer, their first treatment is obviously critical from a psychological point of view. Is that target realistic?

Ms Daly: It is actually still a challenging target. It is a target that applies in GB as well, so it is consistent with the target there. We are always looking at trends, what happened in the past and where there is scope to improve. That target was in place last year. It is important, and the Minister wanted to continue to have it in place. It has been difficult to meet the target with performance over the past year, but, when we are working with the Health and Social Care Board, the Public Health Agency and the trusts, we will be looking at areas in which that can be improved. The Health and Social Care Board is regularly involved with the trusts on this issue, and they look at the scope to improve all of those processes and share best practice. Sorry, I am being a bit long-winded, but on the basis of the information that we have available, that is a challenging target.

Dr McCormick: It is also important to emphasise that individual clinicians will judge the priority of individual cases. The target is that almost all such patients will receive their first treatment within 62 days, but many will receive treatment much sooner than that. The judgement on urgency has to be for clinicians to make. There are times when they can and do deliver the first treatment much sooner than that. It depends on the degree of aggression of the cancer. In some cases, a delay of 62 days will make no clinical difference; in others, it will make an immense clinical difference. That is a clinical judgement. It is not possible to constrain or define every detail of clinical management in those targets. It is a broadly based target, but it is absolutely not meant to inhibit the right clinical judgement. People can have great confidence that where a diagnosis is made and urgent intervention is needed, that happens.

The Chairperson: Do you ever get a synopsis of pathways? When you get a suspected cancer diagnosis, you obviously want the first definitive treatment within 62 days, but is there ever a sit-down at a departmental level to discuss the people who were missed? I am thinking in particular of a girl who I heard about recently; I have not spoken about her previously. That girl should have had a needle biopsy, if that is what you call it, but she was missed. She kept going back and being told that she was OK, but she now has breast cancer and it is at a very advanced stage. She is not going to live. She has twin boys. How often do the people who make the decisions at the financial end of the Department get the human stories that help to decide what the priorities should be? If you have a very aggressive form of cancer, 62 days is an awfully long time to wait for treatment. I accept what you are saying about people being seen earlier, but I am interested to know whether you ever get to hear the human stories.

Dr McCormick: I can assure you that the input to the process includes significant contributions from all the professionals in the Department, who, in turn, have very good advisory networks with clinicians and are very sensitive to the point you make. We also have to be very alert to a good system of early alerts and reporting of adverse incidents. Where things are missed there needs to be awareness. Lots of those issues come to my personal attention, and we are always asking why something was missed and what can be done. No system is perfect, but we have to challenge the system all the time and challenge ourselves on what is happening to ensure that the focus of the system is on quality and safety and that we avoid that kind of missed opportunity and missed diagnosis. We have to take those things very seriously. I can only sympathise totally with that case; it should not have happened. In a complex system, we have to find out why and get to the heart of the issue.

Ms Daly: I will pick up on the point about the 62 days. Andrew talked earlier about minimum standards. That is a standard; it is the least that has to happen. There are indicators of performance for cancer care. We would expect that the trusts and the board are focused on those — and probably on a whole range of other things as well — and not just on the targets, but, as Andrew said, we cannot pick up specifically on the issue that you raised, Chair.

Mr Brady: Thank you for your presentation. In the list of ministerial priorities, it says that there is a priority:

"To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after across all our services."

With the advent of welfare reform/cuts, has that been factored in? Those people will be at the sharp end of the cuts. Obviously, that will put more pressure on the health service. Benefits are being cut,

and we have the introduction of personal independence payments to replace disability living allowance (DLA) and the migration of people on incapacity benefit to jobseeker's allowance. That will all have an impact. We also have the advent of universal credit and families being paid monthly as opposed to weekly, Iain Duncan Smith's premise being that, if people get paid monthly, they will be used to being paid monthly when they get these mythical jobs that are, apparently, out there. That will impact greatly on those people, and I am not sure whether all of that has been factored in. We have been aware since at least 2008 that welfare reform is coming. I do not think that planning ahead can be done in isolation. We are going to lose approximately £700 million out of the welfare benefits budget here in the North.

Ms Daly: You are absolutely right; I completely agree with that. The Department is engaged with the Department for Social Development (DSD) on work on universal credit. Eugene has been involved in that work as regards the read-across and the implications for health. It is at a fairly early stage. Andrew mentioned the whole systems approach, and that is part of what we have to do. We have to bring together all aspects of the issue in relation to the Programme for Government and the economic strategy. All of those things will impact on health, and we have to ensure that this programme is comprehensive and properly structured. It will be a massive challenge. It is very complex, and it is easy to say that there will be structures and that we will take it forward. It will actually be a very challenging time over the coming years. However, we absolutely need to ensure that we take account of all of those things.

Dr McCormick: We should put the point that you made to our statisticians to make sure that there is a projection of the trends in societal income and that we look at that, because the numbers quoted are clear.

Mr Brady: The previous Government in Britain, the Labour Government, talked about the eradication of child poverty by 2010 initially and then by 2020. However, there will now be an increase in child poverty and fuel poverty. I was listening to something on the radio this morning about us having lower prices and a lower standard of living here, but we pay more for electricity, gas, oil, food, petrol and diesel. I am not sure where that came from. If you cut that, it will have a knock-on effect. As with child poverty, there will be all the attendant problems, particularly in relation to health. We need to be aware of that.

Dr McCormick: I take your point. The Office of the First Minister and deputy First Minister (OFMDFM) and DSD are working on the child poverty strategy. We need to link into that and ensure that we are fully aware of what is going on so that we can contribute to that process.

The Chairperson: I have a couple of questions. Are any of the other strategies that the Department has been involved in not fed into this? For example, I imagine that the maternity strategy would have identified a number of targets, but there is very little on maternity. For example, one of the Minister's targets is on elective caesarean sections and reducing the number of caesarean sections. That is not in there either. If all the strategies are supposed to be coming together, that is something that has been missed. There are probably other examples that I have not thought of.

Dr McCormick: If you refer to page 16 —

Ms Daly: It is in the direction on indicators of performance. Again, there are a number of indicators of performance in relation to maternity and young children. I want to pick up on some of the issues you mentioned in respect of the percentage of babies born by caesarean section and the number of babies born in midwifery-led units, be they free-standing or —

Dr McCormick: — alongside a consultant-led service.

Ms Daly: Yes. Again, the point is that it is not that the delivery of those targets is not important. The consultation on the maternity strategy has now been completed and was well-received. Take even 'Transforming Your Care'; that very much reflects the whole direction as envisaged under the maternity strategy. It is absolutely expected that that would be reflected and included in the commissioning plan. The fact that it is not included as a specific target does not take away from that. It is about trying to

move the emphasis away from focusing on process and activity targets to focusing on outcomes. Those specific elements are included in the indicators of performance direction.

Mr Rooney: There is a general requirement in the wording of the direction itself that the plan that is produced should take into account the policies and strategies of the Department. So, we would expect to see significant strategies covered in the plan that comes forward to the Department for approval.

The Chairperson: One of the targets is for at least 50% of outpatients to be seen within nine weeks. However, in the commissioning direction for 2010, the target was for 100% of outpatients to be seen within nine weeks. For diagnostic tests, the waiting time is the same as it was in 2010. Then again, the target for inpatient appointments is 50% within 13 weeks, whereas the target in 2010 was 100% within 17 weeks. So the targets are actually going backwards rather than forwards. It is very regrettable that we are in this situation. We are trying to get back to what had previously been the norm.

Dr McCormick: The sequence is that we introduced a target of nine weeks, nine weeks and 13 weeks for outpatient appointments, diagnostic tests and inpatient appointments respectively for the 2009-2010 financial year. We were making good progress for a while. I think that capacity was and still is a significant issue. The Health and Social Care Board has done some very good work to develop a better balance between demand and capacity in the past two years. It is about trying to find ways to bear down on demand. This is where a public health, early intervention-led strategy is so critical for the totality of our system. If that is successful, it impacts on access as well. We are trying very hard to make progress on that.

I can remember acknowledging, either to the Committee or at some other Assembly event, that it was with great regret that we had to draw back from the purity of the nine-, nine- and 13-week targets in reference to "at least 50%". That was a step backwards, and it was taken in relation to the 2011-12 financial year. We cannot realistically ask the service to improve on that while there are unresolved issues of capacity and performance. It is very challenging.

That is partly down to the fact that not all of the demand in the system is being met and funded. We are not able to commission. Part of the focus here is on the performance of the trusts, but an equally important dimension is to ask whether we are commissioning enough services. Have we the resources to commission enough services? Those are not straightforward questions at present.

I want to express regret that we have not been able to sustain the nine-, nine- and 13-week targets for outpatient appointments, diagnostic tests and inpatient appointments respectively. That is not good. I accept what you are saying. However, what we have here is the realistic maximum expectation at present.

The Chairperson: OK. We very much welcome the fact that we have had this session. It would not have been acceptable or in anybody's interest, Andrew, if we had got just a flavour of the plan. Points have been made about the commissioning direction, the timeliness of it and when we get it. If the Committee and the Department are to have a good working relationship, we need access to such information early so that we can give you a sense of how we feel about it. I appreciate your coming to the session today.