



Northern Ireland
Assembly

Committee for Health, Social Services and
Public Safety

OFFICIAL REPORT (Hansard)

Commissioning Plan 2012-13:
DHSSPS/HSCB Briefing

6 June 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:

Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Ms Michelle Gildernew
Mr Kieran McCarthy
Mr Conall McDevitt

Witnesses:

Ms Catherine Daly	Department of Health, Social Services and Public Safety
Mr Eugene Rooney	Department of Health, Social Services and Public Safety
Mr John Compton	Health and Social Care Board
Mr Dean Sullivan	Health and Social Care Board

The Chairperson: Eugene, Catherine, John and Dean, you are more than welcome to today's meeting, and thank you for the information that you provided to the Committee. John, I assume that you are taking the lead, so I will hand straight over to you.

Mr John Compton (Health and Social Care Board): Catherine will take the lead.

The Chairperson: Apologies, Catherine.

Ms Catherine Daly (Department of Health, Social Services and Public Safety): No problem.

The Chairperson: You are becoming a regular at the Committee, Catherine. I will hand over to you to make the presentation and then open up the session for questions or comments. I apologise that I need to leave at 3.00 pm.

Ms Daly: Thanks very much, Chair. My colleagues and I are very grateful for the opportunity to speak to the Committee about the commissioning plan for 2012-13. I am accompanied by John Compton and Dean Sullivan from the Health and Social Care Board (HSCB) and Eugene Rooney from the primary care directorate in the Department. Chair, if you and members are content, I propose to give a short outline of the commissioning plan process to date, the purpose of the plan and the stage that we have reached. Following that, we will be happy to answer questions from the Committee.

First, I will set the statutory context. The Health and Social Care (Reform) Act (Northern Ireland) 2009 is the legislative framework within which all Health and Social Care structures operate. Section 8(3) of the Act requires the Health and Social Care Board to prepare and publish a commissioning plan for each financial year after consultation and agreement with the Public Health Agency (PHA), the intention being that the commissioning system has public health at its heart.

The Minister's priorities and requirements of the board are set out in the commissioning plan direction. It specifies the required form and content of the commissioning plan in respect of the services to be commissioned and resources to be deployed for those services. For 2012-13, in addition to the commissioning plan direction, the Department issued indicators of performance direction. Effective performance management of Health and Social Care services requires the availability of a range of indicators to help to track trends. The indicators of performance direction have been produced to ensure that the sector has a shared understanding of the indicators that should be in place, and which should have a common definition, across the sector. The Health and Social Care Board and the Public Health Agency are expected to monitor the trends in those indicators and take appropriate action to address performance issues where they deem that to be necessary.

Members will recall that we gave a presentation to the Committee on the commissioning plan direction on 1 February 2012. Subsequently, the Minister wrote to the Committee Chair on 27 February 2012 in response to a number of points that had been raised at the meeting on 1 February. The commissioning plan direction and the indicators of performance direction were issued to the board and the agency on 29 February. The Minister wrote to the Committee again on 14 March to advise that the direction had been issued formally.

Since then, the board and the agency have worked to develop a plan in response to the direction. A draft commissioning plan was submitted formally to the Department on 30 April. In line with legislative requirements, that draft plan was approved by the boards of the Health and Social Care Board and the Public Health Agency on 26 April and 30 April respectively, prior to the formal submission of the draft plan to the Department. A copy of that draft was provided to the Committee under cover of the Minister's letter of 16 May. At that stage, the Minister advised that the draft plan was being considered by the Department against the requirements of the commissioning plan direction. Comments on the draft plan were provided by the Department to the board and agency and are being considered by them.

That details the stages of the process and where we are. Clearly, the key focus will be on the substance of the plan to be delivered. When we gave evidence to the Committee in February, we highlighted the Minister's desire to shift from a focus on targets and processes to a focus on outcomes and quality. The commissioning plan direction for this year has fewer targets than the one for 2011-12. That is not to say that targets are not important. People will always want to be assured about, for example, timely access to care. However, in the commissioning plan direction, we have attempted to build a stronger focus on outcomes. More work remains to be done on that, and the Minister has made it clear that he wants to go further.

Next, the draft commissioning plan has to be finalised, taking account of any issues raised by the Committee and the earlier comments from the Department. It will then go to the boards of the Health and Social Care Board and the Public Health Agency for approval before being submitted to the Department for approval by the Minister.

We are now happy to take any questions from the Committee.

The Chairperson: Catherine, thank you. Perhaps you can give us a wee update. I know that the population plans must be finalised by the end of June. How do they fit into the commissioning of services to the said population in constituencies?

Mr Compton: It can be confusing for people. The production of both population plans and a commissioning plan makes this year unusual. A commissioning plan for this year is a requirement, and it is a one-year plan, whereas the population plans are for a longer period. As we move through to 2013-14, the two processes will merge into one set of arrangements. That is simply to do with the timing and context of this year.

As you know, population plans focus on the implementation of the 'Transforming Your Care' report. The commissioning plan is a direct response to the commissioning plan direction but contains nothing that cuts across that report, which had already been published and so was taken account of. The

commissioning plan is a one-year document, whereas the 'Transforming Your Care' document covers three years. The two will head into the one place next year.

The Chairperson: The draft commissioning plan contains overarching policies and objectives. How do they fit into local areas? One priority is, for example, to tackle obesity. Can a local commissioning group, if obesity is not a problem in its area, ignore that strategy?

Mr Compton: Local commissioning groups should not ignore any formal strategy.

The Chairperson: Sorry, maybe ignore was the wrong word. A regional commissioning plan targets certain problems, and each area will receive a population plan. A local commissioning group knows what the local health inequalities are, and a certain issue or problem might not fall into a strategy in the overarching commissioning plan. Is there a mechanism that allows that local commissioning group to say that a certain issue should not be a priority in its constituency and that something else should be?

Mr Dean Sullivan (Health and Social Care Board): Certainly, there is the opportunity for local commissioners to prioritise, taking account of the different pattern of services and the different needs of their population. However, there is a broad expectation that although all local commissioning groups will not pick up each regional priority in the same way, we expect that they would consider it appropriately as part of their local commissioning planning processes.

The Chairperson: So local areas cannot ignore the priorities of the regional commissioning plan.

Mr Sullivan: That is right.

The Chairperson: There will, however, be mechanisms to ensure a localised approach to some issues.

Mr Sullivan: Yes.

The Chairperson: You said that Transforming Your Care will extend beyond the one year of the commissioning plan. However, unless I have got it wrong, everything comes together on the same journey after a year.

Mr Compton: That is correct.

The Chairperson: You say that it is urgent that the population plans are completed by the end of June.

Mr Compton: That is correct.

The Chairperson: If the commissioning plan covers a year, what is the rationale for that?

Ms Daly: It is a statutory requirement to have a commissioning plan for each financial year, so this one takes account of the commissioning that will be required from 1 April to 31 March. As John said, the population plans are required to be produced by the end of June. Future commissioning plans and population plans will be dovetailed and aligned. We expect that the processes for the commissioning plans and the population plans will be progressed together in future years.

Mr Compton: The commissioning plan also articulates, in the year, the financial plan for the expenditure and commitment of resources in 2012-13. That will allow us to signal those resources to areas where they will be spent on the delivery of health and social care requirements. That is an important feature of the 2012-13 plan. The population plan does have a financial profile, but it is across the three years. The commissioning plan is a specific financial profile for the current year.

The Chairperson: I have a couple more questions before I open the floor to members. Some people have told us that they have heard a lot about Transforming Your Care, but that, unless they are anoraks like us, probably do not know what it means. The public do not realise the importance of Transforming Your Care. I am aware that the Patient and Client Council has written to the Minister to ask whether a leaflet could be sent through people's doors to highlight what Transforming Your Care

is. I am using this opportunity to say that because representatives of the board are here. In a similar vein, we are asking the population to get involved. They also have a part to play in tackling health inequalities and in addressing their health needs and the lifestyle of their community. Will that information go out in some form? Will it be localised? When we talk to people outside of those directly or indirectly involved in health about local commissioning groups and the board, we find that they do not have a clue.

Mr Sullivan: You make two separate points, Chair. One is about the structures and processes that are in place to take forward commissioning, and the other is about what is being commissioned and what can reasonably be expected, locally or regionally.

On the first point, I think that your idea was helpful and that perhaps we could reinforce the message about the commissioning structures in a better way than we have done to date. Certainly, we rehearse that each year in the commissioning plan, even though we have been up and running now since 2009, and we do so for precisely that reason: to navigate people through the structures. However, it would do no harm to have something outwith the commissioning plan that does that.

As far as the messages in the commissioning plan are concerned, a summary draft is being produced. Pending the Minister's consideration and approval of the final plan, it will be finalised and published shortly thereafter. That summary will be a more accessible version of what is a weighty tome. It will explain more straightforwardly some of the key elements in the commissioning plan and what the public can reasonably expect to receive from Health and Social Care this year and beyond.

Mr Compton: It is also important to reflect that in the production of the commissioning plan. It is a point in time, but it is, if you like, a running movement. You will see that a huge amount of the draft commissioning plan has been produced in collaboration with all sorts of interested parties, including local groups, voluntary organisations and strong constituency interests. So much of it is produced in, if you like, a running way with a huge amount of engagement, which takes place all the time in Health and Social Care. The document partly marks a point in time with the Minister's targets, but it also reflects some of what we are and have been hearing in the previous year during our preparations. So the commissioning plan is not written in a back room somewhere; it is written very much as a consequence of a great deal of dialogue with many interested parties.

The Chairperson: I appreciate that, but I am talking about the general public. Unless people have an interest, they will not know much of the detail.

Ms Daly: I just want to pick up on that point, Chair. During consultation on the population plans, it will be critical for us, working with the board, to ensure that those issues are clearly communicated to all stakeholders and public interests, because health issues affect everybody. That will involve, for example, using everyday language that people understand. I appreciate the point about our working in detail with local commissioning groups and the various sectors to make the commissioning process easier to understand. It affects everybody, so it is our responsibility to ensure that the consultation is done in a way that makes it clearly understood by everybody.

The Chairperson: Most, if not all, councils send out fridge magnets with useful numbers on them. If you lifted some of the information and got it through every door, it would bring the 'Transforming Your Care' document closer to more people — people outside of those who have an interest in it. Recently, we have heard a lot of talk about Department circulars and seen many statistics on targets not being met throughout the health service. Does the board have a strategy or policy in place to target trusts that do not meet the targets that are set?

Mr Compton: The short answer is yes. Dean will talk about the targets. We thought that you might go there, so we have some information.

Mr Sullivan: Some organisations will always face challenges in meeting certain targets, particularly when resources are as constrained as they are. Notwithstanding the resource context in which we work, there are a number of examples of significant progress being made in recent months, and I will share some of those with colleagues. There has been progress on the elective care side: in outpatient assessments; diagnostic tests; inpatient and day-case treatments; and huge reductions in waiting times. Back in September, almost 60,000 patients were waiting for more than nine weeks for an outpatient appointment; by the end of March that number had fallen to 29,000 — a reduction of 52%. In September, 27,000 patients were waiting for 13 weeks or more for surgery; by the end of March, that figure had fallen to 18,000 — a reduction of 30%. In September, 5,600 patients were

waiting for more than 13 weeks for endoscopic tests for cancer and other conditions; by the end of March, that had fallen to just three.

The Chairperson: Three patients or three weeks?

Mr Sullivan: Three patients.

The Chairperson: Very good.

Mr Sullivan: As Catherine pointed out, it is clearly in the Minister's gift, but it would not be appropriate for the Department to seek to set targets for everything, because we would end up dispersing the focus too far. Notwithstanding that, the issue of waiting for outpatient review was around in recent years but was not a ministerial target. Although we have not fully addressed that issue yet, there has been huge progress in the past year. We have gone from almost 80,000 waiting longer than clinically indicated for a review appointment to just over 30,000, which is still too many. However, even within that 30,000, the length of time over the clinically indicated time is much shorter, and we will continue to press on that during 2012-13. As has ever been the case, certainly when I was with the Department and since I joined the board in 2010, there are always lumps and bumps surrounding the achievement of targets. However, I assure members that the board is hugely focused on that area, with targeted interventions across all the programmes of care to ensure that we maximise the performance of all organisations. That does not mean that John or I can give a categorical assurance today that all targets will be met. Unfortunately, life is more complicated than that, especially when dealing with numbers as large as the tens of thousands of patients moving around in the system. However, I assure colleagues that we will continue to press very hard to maximise the service provided to patients.

Mr Compton: Our expectation is that the improvements made since the middle of last year through to March will continue and that there will be further significant movement in that area in the first half of this year.

The Chairperson: I give credit where credit is due on that target. I assume that there is an action plan to push the targets. There is no point having a commissioning plan if there is no strategy.

Mr Compton: Specifically, Dean and his staff meet fortnightly with each of the providing organisations to go through the numbers. Behind all of this, we have what we call a demand-capacity analysis, so we know how much activity can be done in each particular facility across the Province: how many theatres are free and how much activity can go through a theatre. We call that the core contract. Our expectation is that each organisation delivers to its core contract. We understand only too well that, occasionally, staff are ill or they move or change jobs, and that can cause difficulties. However, as long as we understand what is happening and how, we are reasonably content. Anybody who drifts offline is asked to give us a reasonable explanation. This is all about a sense of proportion, balance and reasonableness, because that is what secures the improvement.

We have a similar process for cancer. Also, we have started, as you know, the new process on A&E, which is beginning to show some improvement, particularly on 12-hour breaches, across the region. A whole set of arrangements is in place to ensure that no organisation is left adrift in the middle of all this and that we address promptly particular problems that are not being addressed.

Ms Daly: A range of targets is set in the commissioning plan. However, if something is not a target, that does not mean that it is not important. The commissioning intention spans the totality of services. This year, we included an explanatory note in the commissioning plan direction, which sets out very clearly the comprehensive nature of that intention.

Mr Wells: First, John, I have an apology. At the previous meeting, I used a phrase in jest that looks dreadful in cold, hard print. I said that you were the "master of spin". That was entirely humorous, but I know that it did not seem that way when it was read.

Mr Compton: It was taken humorously.

The Chairperson: You did not read it. *[Laughter.]*

Mr Wells: It was in the context of my saying that you could convince me that swans are black and crows are white. Some people picked it up as being meant seriously but it was not. A lesson has been learned.

One of your targets is:

"40% of the remaining long-stay patients in learning disability and psychiatric hospitals are resettled ... by March 2013".

I thought that an earlier ministerial target was that nobody would be in long-term care in places such as Muckamore by 2013.

Mr Compton: You are right about the 2013 target. The Transforming Your Care arrangement and the practicality of building new facilities and houses meant that the target was revised to 2015. Some of the difficulties relate to the construction of housing with care and our working jointly with the Department for Social Development (DSD). In no way should that be taken as any criticism of DSD, which has been working very well on all that. It is about our ability to work together. The target now is 2015, and we are well on our way to meeting that. This year, for example, by the end of March, a few people still had to be resettled, which was largely to do with one or two schemes running a little behind in their construction and opening. However, we expect to get there very quickly in the current year.

Mr Wells: There is a view among representatives of the patients, in Muckamore in particular, that it would not be appropriate to ask some individuals there to leave and resettle in the community at any stage. Their families would support their remaining in Muckamore. It is implicit in what you are saying that their wishes will not be adhered to.

Mr Compton: This can be a very difficult area in which there needs to be tremendous sensitivity. We cannot simply move someone who, perhaps, has spent 10 or 15 years in hospital care to another area of living. We have to work sensitively with the individuals and their families. The expectation is that we will move away from a position in which anyone remains in hospital simply as a point of residence. Clearly, people may require to be in hospital because they have particular problems and difficulties that are best managed in a hospital environment, but it should not be the case that hospital turns out to be a person's home. We will work with families. My experience is that there is a fair bit of sensitivity in the handling of all this. It requires us to talk to families and show them real opportunities and alternatives, and not simply create anxiety and distress for them. In the long term, we are moving away from institutional care, as it is sometimes referred to — rather pejoratively, because it is excellent care — so that people will not live in that situation for life but in much more normal environments. We will deal with that in a sensitive manner.

Mr Wells: I was too busy falling on my own sword and forgot to ask you a more fundamental question earlier. We are 20% into 2012-13, and we are now getting the finalised commissioning plan. I know that you will say that we are in a much better position than last year, but am I not right in thinking that you should have had the commissioning plan before the beginning of the year that it covers?

Mr Compton: That would be the case in an ideal world. However, the process was that we received our commissioning direction in February, and we have put together a draft document. We have to talk to the Department and the Committee, and we have to hear from one or two other people. When we send our final document to the Department on 11 June, we will be in a much better position than we were last year. Ideally, we would like the plan to have gone through the process and be completed in March of any given year. However, we have done much better this year, and I hope that we will improve again next year.

Mr Wells: Well, that is what I asked you. Next year, can we expect the commissioning plan for 2013-14 to arrive before that year starts?

Mr Compton: Assuming that the individuals who are involved across a range of systems and processes give us a commissioning direction in a way that allows us to produce the plan by then, we will do so. There is no issue with that.

Mr Wells: We are coming to the stage at which the population plans will be published on, I think, 22 June.

Mr Compton: It will be in late June, or at the end of June. We are still finalising those with the Minister. He has to set a date for making a statement to the Assembly on the population plans. That will be at the end of June or the very beginning of July, probably in the last week of June.

Ms Daly: The date in the 'Transforming Your Care' document is 30 June.

Mr Wells: So we will have those population plans and the commissioning plan. The draft commissioning plan is almost identical in some of its phraseology to 'Transforming Your Care'. You would almost think that the same guy wrote, or had been involved in, both. After the population plans are published at the end of June, they go out for consultation. How meaningful is that consultation, given the fact that the wording in this draft document is so similar to the 'Transforming Your Care' document? In other words, have you not pre-empted, to some extent, the outcome of the consultation?

Mr Compton: I think it fair to say that there is nothing in the commissioning plan that would smile against 'Transforming Your Care' as a document, and it would be unusual if it did. The real difference in the consultation is that 'Transforming Your Care' contains 99 recommendations, whereas the population plan is from a service perspective. In other words, it concentrates more on the service perspective and less on any legislative changes that might be required. It indicates how the service will reorientate to deliver those recommendations over the three- to five-year period. I think that that is different and that the consultation is, therefore, extremely meaningful. People will understand what it is; what is the end point in any position; and what are the stepping stones in reaching that end point. They will have an opportunity to say whether they are content, or otherwise, submit queries and make suggestions for change.

Mr Wells: How could the whole process work if the outcome of the consultation on the population plans led to a conclusion that was at odds with the commissioning plan? How could that physically happen?

Mr Compton: The commissioning plan is for one year, whereas 'Transforming Your Care' set itself a five-year agenda for a transformational programme. Consider, for example, some of the areas of contention, or that are likely to be contentious, such as what the public think about having between five and seven hospital networks. That cannot happen within a one-year period, even if we wanted to make a change. It would have to happen over a period that allowed the change to be planned. People will, quite rightly, have a view on that and want to contribute to the debate. So the population plans will signal how that might work; how the integrated care partnerships might operate in primary care; or how services for older people will be reshaped over the five-year period. The commissioning plan is entirely about the year 2012-13, and it does not imply that there will be major change in the course of that year. It assumes that the change will commence, if it is to commence, in the final quarter of 2012-13 and after any consultation period.

Mr Wells: Target 15 states:

"From April 2012, no patient should wait longer than 9 months to commence NICE-approved specialist therapies".

Obviously, we are talking largely about anti-TNFs (tumor necrosis factors). [*Inaudible due to mobile phone interference.*] I hope that that is not my phone. It is, sorry. It was on silent but not switched off. That is three apologies that I have had to make this afternoon. I must do better.

We are talking about anti-TNFs for conditions such as rheumatoid arthritis (RA), colitis and cirrhosis. Now that we are 20% into the year, are you meeting that nine-month target? Are you certain that you will meet the three-month target by September? That would be very welcome to societies such as Arthritis Care, the National Association for Colitis and Crohn's Disease and those who represent people suffering from cirrhosis. It would be great to say that we are meeting the nine-month target and that the three-month target is a shoo-in. Is that the case?

Mr Sullivan: I suppose, going back to earlier comments, that nothing is ever a shoo-in in this arena. You would not have to wind the clock that far back to find patients waiting two and three years for some anti-TNF treatments. I have not gone through the performance numbers against that target, so I will share them with colleagues now. At the beginning of 2011-12, 43 patients were waiting for more than nine months to commence anti-TNFs. From September 2011 and right the way through to now,

no one has waited for longer than nine months. So that figure has come down to zero. We have plans in place that are working towards meeting the three-month target by September 2012.

Mr Wells: Is that an indication that it will definitely happen?

Mr Sullivan: It is as firm as a commitment as I can give. With a fair breeze and provided that we are not hit from the side by something that I cannot foresee, it is my clear expectation that it will happen. There is nothing to indicate otherwise. In our existing plans, our aim is to get the current nine-month target down to six months by the end of June, and we are already on target. With past performance being the best judge of future performance, I have no reason to think that we will not get the waiting time down to three months.

Mr Compton: As you will read, the draft commissioning plan indicates that we are committing the additional £17 million into drugs approved by the National Institute for Health and Clinical Excellence (NICE) during the year, all of it aimed at meeting the three-month target. We are as confident as we can be that, having come from a difficult place, we are meeting the target. The journey is under way, and we should get there mid-year.

Mr Wells: Finally, the target for 95% of patients to be seen within four hours has come up several times already. Having read Rutter and Hinds and seen the problems facing the Belfast Trust, my feeling is that that is really the big one as far as the commissioning plan is concerned. You will tell me that there are hundreds and hundreds of other recommendations. However, it is the same as with your report, John. There are only three recommendations in that report in which the public are really interested, and you know what they are. Similarly, the efficacy of this draft commissioning plan and how much delivery it achieves will be based on whether you hit that target. Given Rutter and all that is going on, are you being realistic in setting a target for 95% of all patients to be seen within four hours? Last year, that target would not have been met for 4,500 people across several trusts. In fact, they waited for more than 12 hours, although there was not a problem in the Southern Trust or the Western Trust. Are you not leaving yourselves very exposed by setting that target?

Mr Compton: First, it is not for us to change or refuse to apply a ministerial target. Secondly, as you know, the Minister has asked us to look afresh at A&E. He has taken a close interest in the accident and emergency departments' performance, with a view to having, as a first order, no 12-hour breaches by the end of June and then moving towards the 95% target. Undoubtedly, the 95% target is a difficult ask. However, I think that, if we can get clear of the 12-hour breaches, it will become much more doable.

This may be a matter of interest to you. As you might imagine, we receive daily reports at about 8.30 am. Today's report indicated only four 12-hour breaches throughout Northern Ireland. We have significantly reduced the number of people waiting for longer than 12 hours. We are pleased that people in the trust are getting to grips with the issue, because the work has to be done by the people on the ground. Once they have seriously got to grips with the issue so that it becomes an irregular or unusual occurrence for anyone to wait for 12 hours, we will move towards the four-hour target. I am hopeful that we will make significant progress during the year.

Mr Wells: I would not say that June is a good time to measure performance.

Mr Compton: I ask for the numbers going in and the flow. We measure the numbers turning up at A&Es each day, and there is no drop. People think that it being June, which is the start of the summer, is a factor, but that was more relevant a number of years ago. The numbers tend to stay fairly static now.

Mr McCarthy: Jim's first question about people with learning disabilities in Muckamore, and I, too, am very concerned because a commitment was given. I know that it did not come from any of you, John, but the Minister and the permanent secretary gave a commitment, perhaps on more than one occasion when before the Committee, fully to respect the wishes of the very few people in Muckamore who do not wish to be anywhere else. I hope that your answer to Jim does not mean a slide in your commitment.

Mr Compton: Not at all. We fully appreciate the sensitivity involved and the need to closely engage and have discussions with families in order to understand their particular issues. I am more than happy to give an absolute assurance to the Committee that such engagement will take place. We

want to get the best living accommodation for all individuals in Muckamore. That requires much detailed negotiation and discussion with families, so nothing will be done without proper engagement with them.

Mr McCarthy: Good.

My other question is about psychological therapies. One of the bullet points on page 144 of the draft plan is:

"Fully implement all the recommendations of the DHSSPS Psychological Therapies Strategy."

On page 149, a key deliverable for 2012-13 is:

"develop a specification for the delivery of a primary care based psychological therapy service".

I just want to check a few things. Will you confirm that the Department will fund the full implementation of the psychological therapies strategy? If so, for how long?

Will you describe what you mean by a "primary care based psychological therapy service"?

Do you agree that you should spend as much on high-level psychotherapy interventions delivered by professionals with specialist training as on low-level interventions?

Mr Sullivan: Taking it back a level, I will start with some hard numbers on patient waiting times. All patients waiting for psychological therapies are being seen within 13 weeks of referral by their GP or other practitioner for assessment and treatment. There have been difficulties before with performance in that area. However, at the end of March, no patient was waiting longer than 13 weeks, which I think gives us a robust foundation on which to move forward. As a general rule, there should be no unfunded commitments in the plan, and I am not aware of any. The funds are available to take forward the commitment to implement fully the recommendations in the Department's strategy.

The primary care/secondary care split is simply down to the Transforming Your Care agenda. There are elements of that service for which patients do not need to go to hospital. Those can be more appropriately provided near a patient's home in a primary care setting, rather than a patient always needing to traipse to hospital to see a consultant or specialist. It is simply about designing what that might look like in a primary care setting, rather than it in any way replacing the need, in certain circumstances, for patients to see someone in secondary care.

Mr McCarthy: What sort of period are we talking about for full implementation?

Mr Sullivan: My expectation is that it will be fully implemented during 2012-13. That is my understanding, and the plan reflects that. If it is different, we will obviously let the Committee know.

Mr McCarthy: Finally, I want to ask about support for carers, which is dealt with in two points on page 33 of your draft plan. Will you tell us in more detail what is meant, first, by "enhanced respite opportunities" and, secondly, "Local carer support structures"? People in some areas find it difficult to get respite, which I know from experience to be a vital part of looking after a disabled person.

Mr Sullivan: We would need to come back to the Committee on that.

Mr Compton: Throughout, there is a clear recognition of the importance of respite care. We will provide details on that.

Mr Dunne: Thanks very much for your presentation today. Following your previous presentation in February, some of us raised a point about the schedule. I take it that the targets in the schedule are in priority order.

Mr Compton: No.

Mr Eugene Rooney (Department of Health, Social Services and Public Safety): Are you talking about the schedule of targets and standards in the commissioning plan direction? No, they are not in priority order.

Mr Dunne: Last time, when we made the point that the target of inviting 50% of all eligible men and women aged between 60 and 70 to bowel cancer screening was a bit low, your response was that at least 55% of those invited took up that invitation. We assumed that the invitation would be just a one-off letter, for which there would probably be a relatively low up uptake. Your target means that roughly 28% of the target population will be screened by the end of next year or March 2013. Is that correct?

Mr Compton: First, there is not just a one-off letter asking people to take up the offer of screening. There are reminders and letters from general practitioners encouraging individuals who did not take up the opportunity to do so. As members will know, screening is straightforward and simple to complete. It is not onerous or difficult.

The targets were structured through the Public Health Agency and reflect the evidence that it has gathered on what constitutes a good uptake and has a major impact. We have fully funded not only the screening programme but its outworkings for those for whom there appears to be a particular difficulty. They are small in number, but it is an important matter for those individuals. If the advice to us is that we need to raise those percentages, we will.

Mr Dunne: By this time next year, 28% to 30% of that section of the population will have been screened. Does that not seem low?

Mr Compton: With the introduction of any screening programme, it takes a certain time for it to get into the psyche of the population so that it becomes commonplace and people start to talk to one other about it. A screening programme such as this cannot be set up and then go from 0% to 100% coverage in a short time. Our programme to get to that position, as I understand it, mirrors best practice in other areas where it has been implemented successfully. There is no prescription not to get there more quickly. If we can, we should, but my understanding is that we are following the best practice and advice.

Mr Dunne: You could significantly increase those figures.

Mr Rooney: Further to what John said, when the Committee raised the issue on 1 February, we sought further information to challenge the figures and wording used. The reworded version was presented to the Committee later in February. As John said, that reflects a challenging target, as far as we have been able to ascertain, for what is achievable within this year. In response to the Committee's queries, we tested the wording and found that it reflected a challenging target, given what normally happens with screening programmes, for the board and the PHA to deliver this year.

Mr Dunne: Thank you. Target 3 is to have in place by March 2013:

"a community pharmacy health promoting pharmacies programme."

Those of us who have been on the Committee for the past year are very much aware of all the issues with pharmacy. In light of those, is that target achievable within the next year? I am aware that the issues are live and ongoing. What is the current position?

Mr Compton: The issues are very much live and ongoing. However, I want to make it clear for the record that the board is very keen to reach a resolution and to support community pharmacy. We see it as a vital and valuable service. There are differences, and they are not insignificant. There is no point in disputing the fact. We hope to close out those differences, but that requires both sides to negotiate. We like to think that we have been trying to negotiate. I am sure that others, if asked, may have a different view. I can say only that we think it an important target and that we want to use community pharmacy extremely well.

At one point, there was much discussion about whether the target would cause problems for rural pharmacies. Those are absolute priorities for us to protect. We are certainly talking about a different type of pharmacy over time, but key constituents of that are the protection of rural pharmacy, which is important, and the protection of the community pharmacy educational programme that they can deliver so readily and properly.

Ms Daly: As with the bowel-screening target, these targets are developed in consultation with colleagues across policy areas in the Department and with the Public Health Agency. The advice that we have received is that that is a challenging but deliverable target.

I note the points that you made about the bowel-screening target. In developing the target each year, we will review the performance in the previous year against targets and improve, where possible, but in a realistic and deliverable way.

Mr Dunne: It is important that the targets are achievable.

My last point relates to cancer care services. Target 6 states:

"From April 2012 ensure that 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days."

To the layperson, 62 days sounds excessive. How do you justify that?

Mr Compton: The target is set in close collaboration with professional groupings, so it is not set artificially or bureaucratically. It covers a full range of different types of cancer difficulty. A target of 62 days does not mean that everybody waits for 62 days: very many individuals will be seen much more quickly. The breast care target, for example, is for referral within 14 days of a suspected diagnosis, or GP concern, to being assessed and diagnosed. We hit that target for 98% of patients. The differential rates in the draft plan reflect the differing complexity, difficulty and gravity of particular conditions.

Mr Sullivan: It is worth noting that, under target 6, the 95% target relates to the time that elapses from patients' first referral by their GP. Therefore, within that 62 days, they must be referred by their GP, assessed by a hospital consultant, have some sort of diagnostic test — magnetic resonance imaging (MRI) or another test — and begin surgery, radiotherapy or other treatment for their cancer. So there is a lot to be done within those 62 days. It can also include a transfer from one of the non-Belfast trusts to the cancer centre in Belfast, which has been a difficulty on some occasions in the past.

Another target against which we continue to track performance is 31 days from a definitive diagnosis of cancer to starting treatment.

As John said, the third target that we closely monitor is for all women urgently referred with suspected breast cancer to be seen within 14 days.

Mr Dunne: Is that target not achievable at the moment but well on its way to being achievable?

Mr Sullivan: Performance against that target has been a challenge in the past. Performance has been, typically, around the mid-80s per cent range. There have been difficulties in urology. However, there is a significant investment programme for urology, with investment in the eastern team in greater Belfast and in the southern team to expand urology capacity there in parallel with other arrangements. There is also a focus on the issue of inter-trust transfers that I talked about. The board expects that performance will continue to improve against that target in an effort to get it back up to the 95% level required as soon as possible.

Mr Compton: We expect that it should be met this year.

Mr McDevitt: I am sorry for missing the beginning of your presentation. I want to ask you about the spending profiles — the budget. Public health is the central theme in Transforming Your Care. However, in the planned expenditure by programme of care, depicted in table 8 on page 38 of the draft commissioning plan, by my calculations, approximately 2% of the total budget goes to the Public Health Agency, which is £81 million out of £3,994 million. About another 0.5% of the total budget, or 1.5% of your budget, John, goes into what you call health promotion. Where is other public health expenditure buried in all those other budget lines, and what percentage of the total can you credibly say is being invested in public health?

Mr Compton: First, producing the budget for the year involves talking to the two separate organisations. The Public Health Agency looks after its resource and we look after ours. We do not end up in any particular dispute about not making available to the Public Health Agency any resource that it regards as appropriate, or in proportion to, its deliverability.

To be honest, it would be difficult for me to give you anything other than a speculative percentage of the money that we provide for services, but much of what we spend carries with it the whole public health agenda, including, for example, secondary prevention. Also, we see the money that we spend on pharmacy as an important component. Yes, pharmacy is about getting people their prescription drugs, but it is also about giving advice, guidance and proper information.

So the answer is that I do not know. We have never sat down, although maybe we should have, to work out what is a "credible" percentage of the resource invested in public health. This year, much of our investment in demographic services for the elderly will focus on service. However, investment will also be made in education and providing services that provide secondary preventative elements, such as giving people the opportunity to understand fall prevention, nutrition, hydration, and so on. Those are all part and parcel of the one service, so it is not that the spend is on one thing or the other. Maybe we should do some work on that to reassure you.

Mr McDevitt: Pages 55 and 56 contain an interesting but shocking set of figures on the conditions facing the 20% most deprived areas, or approximately 340,000 people, which is a significant number. You point out that individuals in those circumstances enjoy a much lower life expectancy than the average in the region: they are 40% more likely to die before the age of 75. The rates of emergency admissions are 23% higher, rates of respiratory mortality are 66% higher and rates of lung cancer are 65% higher. Finally, there are two exceptionally high figures: rates of suicide are 73% higher and alcohol-related deaths are 120% higher. That is the public health challenge, is it not?

Mr Compton: It is.

Mr McDevitt: That takes me back to my earlier question: if you know where the problem is, surely you need to be able to prove to us that that is where the money is going.

Mr Compton: Yes.

Mr McDevitt: I will ask you the question another way. I appreciate that you cannot answer my question about public health, but how much of the money is going towards those 340,000 people? Where is money being spent to improve their circumstances?

Mr Compton: First, it is important to have an appreciation of what we refer to as capitation. How we spend our money is calculated using a capitation formula, which is a derivative of the total population and the total number of issues of deprivation, difficulties and complicated areas — in which those 340,000 commonly reside — and the proportion of children and older people. The formula that sets out how we spend and commission our money takes account of that at a global level. So when we indicate spend on a "fair share" basis, that is skewed to take account of many of the issues referenced in our draft commissioning plan, and that is a given — we do not simply divide the money per head of population. In the area of family and childcare, for example, certain parts of Belfast will receive £1.60 per head of population as opposed to £1 because the formula takes account of those sorts of issues. The same applies all the way through.

The other issue for us, which is in 'Transforming Your Care' and came up when I was asked to talk to people, is what success would look like. For me, one measure of success will be that those numbers will have changed. It is as simple as that. If we cannot make inroads into some of those numbers, whatever we are doing, we are not approaching the task correctly. We have to be very clear about those target areas and the whole "shift left", as it is referred to.

Ms Daly: I will pick up on what John is saying. I agree that looking at the figures in isolation makes it difficult to see the underlying policies and priorities and how the figures were arrived at. The capitation formula is critical, because it takes account of a number of factors. We would be happy to provide the Committee with more information about that. It is also important to highlight the commitment in the Programme for Government to increase the public health budget, which reflects clearly the priority of ensuring additional funding for that area.

Mr McDevitt: I appreciate that, Catherine. My point is that, when we look at the figures, it is very difficult to see where that commitment has been made good.

I want to ask specifically about the spend on family health services. You talked about the public health agenda being at the heart of all this, yet 56% of the total spend on family health services goes on pharmacy. It stretches credibility a little to say that pharmacy, in its current state, is at the forefront of public health, unless, of course, and as we all hope, you reach a resolution with a better contract.

Mr Compton: It is complicated. If the problem were more straightforward, I am sure that we would have resolved it a good while ago. First, in 2011-12, we reduced pharmacy spend by £30 million. At the start of the year, many saw that as an eye-watering target, but we delivered it in full. We are absolutely committed to using fewer, and more appropriate, prescription drugs across Northern Ireland. As you rightly point out, we spend about £1 in £9 on that, so it is a huge issue for us. However, that relates to the total system. That is why the integrated care partnerships will work differently to examine how drugs are prescribed, consider alternatives to pharmacological products and assist with some of the lifestyle-oriented issues, and so forth.

The public health agenda is across the entire system, and pharmacy has its part to play. We have set very challenging targets for pharmacy in the incoming year, because we believe that that is perfectly reasonable. A number of major drugs that are very commonly used are coming off patent this year, so we are very mindful of that and of the opportunities that it will give us.

Mr McDevitt: I want to ask about accountability. Who, ultimately, owns this? Who has responsibility?

Mr Compton: For pharmacy?

Mr McDevitt: No, for the commissioning plan. Who has absolute and ultimate responsibility for the plan?

Mr Compton: Once the plan goes through the proper due processes, it is ultimately for the board to ensure that it is delivered.

Ms Daly: That is absolutely right. It is the board's responsibility to deliver on the plan, which is subject to ministerial approval and reflects the Minister's policies, priorities and targets. The board is accountable to the Department for the plan's delivery and will work with the trusts on performance management to ensure that.

Mr McDevitt: What is the consequence for the trusts if they miss a target? Do you fine them? Do you penalise them? Where is the stick?

Mr Compton: Where is the stick? Well, clearly, on the elective side, if things are not done, people do not get paid. It is nothing more remarkable than that, and that has been an established process for some time. Through what is known as a framework document, which outlines the way in which we are all meant to interrelate, we have the ability to escalate problems, which we have done. Having appeared before the Committee at a recent meeting, we escalated something that appeared in the reports by Rutter and Hinds about which we and the organisation concerned were unhappy. Ultimately, we can signal to the Department, and to the Minister in highly unusual or unique circumstances, any level of disquiet that we might have.

So there are processes by which a matter can be escalated. We meet each organisation fortnightly to discuss elective care. Most organisations come prepared to those meetings, and they understand what the expectations of them are. We go through those in a mature and sensible way, because this is about partnership. Everyone expects an occasional stick, but that is not really what it is about. It is about a real understanding of what the issues are and working with the delivery side to make sure that we enable the system to work well.

Ms Daly: As John said, the framework document clearly sets out the roles and responsibilities. The chain of accountability is that the board is responsible for the performance management of the trusts and accountable to the Department for that performance. So the Department will work with the board at all stages on performance management, and it will hold the board to account.

Ms Gildernew: You are very welcome, and thank you for your presentation. I will try not to repeat questions already asked. However, I, like other members, am curious about the bowel-screening target, which seems a little unambitious. My parents fit into the 60-71 age bracket, and on the back of an excellent presentation that the Committee received last year in Altnagelvin, I talked to them about

the bowel-screening programme and its positive outcomes. I feel that the bar has been set very low. Talking about screening less than 30% of the population is, I think, an own goal. The early identification and treatment of problems through screening is cheaper than much more invasive surgery later.

Mr Compton: It is, yes.

Ms Gildernew: Will you elaborate a wee bit, John? I listened to what you said, but I am still not convinced about why the bar is set so low.

Mr Compton: We took advice from our Public Health Agency colleagues about what is the best way, with a full understanding of all the issues, to introduce the screening programme to ensure its proper delivery, and the targets were set accordingly. The advice given to me was that they are quite challenging, and they will move up over time. The expectation is that we will run a much more complete bowel-screening programme. The simple fact is that it takes time to do so properly and in an organised way. That is the only issue.

If our colleagues in the Public Health Agency advised the board that we could accelerate the programme, we would, of course, seek to do so. This is simply about introducing something that was not here before, except in a voluntary or diagnostic way when individuals went to hospital, and involving and engaging the total population. The evidence that we have is that we are introducing the programme in the way that is most likely to produce a successful outcome. There is no desire not to do so any more speedily if we could. We are simply taking advice on timescales, time frames, and so on, from the professionals and other places that have introduced it. If we can proceed more quickly and get ahead, we will do so. There is no issue with that.

Ms Gildernew: On the same day at Altnagelvin, the Committee was also given a presentation on the human papilloma virus (HPV) pathway, and the Western Trust's pilot project was innovative. There is no mention of that in the targets. Are you planning to roll out new HPV screening as opposed to the current pathway that applies to most women?

Mr Compton: For it to be a formal screening programme, it would have to come under the formal screening arrangements. If it is considered, becomes a ministerial target and goes through that whole process, we will be asked to deliver it. We have had an interest in trying to get a better outworking of the HPV programme. To be honest, I cannot sit here and answer your question in respect of each of the organisations, but I am more than happy to come back to do that. I recall that you asked me previously, and we got information that showed that we were making considerable progress. I cannot remember the details, but I will let you have that information.

Ms Gildernew: That would be very helpful, thank you.

My next question is about the allied health professionals (AHPs) target of no patient having to wait for more than nine weeks from referral to commencement of treatment. Given the nature of the complaints that AHPs deal with, we previously discussed self-referral. We talked about the number of people who, for example, are off work with a bad back, cannot drive, cannot get to and from work, cannot sit at a desk all day, or whatever. We felt that they could be dealt with much more quickly.

Mr Compton: In a different way.

Ms Gildernew: From an economic point of view, as well for mental health reasons, surely it would be much better to treat people earlier and deal with their problems to enable them to return to work.

Mr Compton: First, if you look at fixing the target timescale, you will see that we have made quite dramatic progress in the context of the year just ended. Numbers peaked, and from memory, I think that we had many thousands.

Mr Sullivan: We had 6,900.

Mr Compton: However, we had only about 500 people at the end of the year and are on our way to getting that figure down to zero.

Secondly, the way in which we are asking integrated care partnerships to work in primary health and social care is at the heart of that. The man or woman in the street might say, "I know that I have a bad back, so why can I not see a physio? The physio will sort it out." That is at the heart of having integrated care partnerships. We are keen to make it a much more straightforward experience for individuals who need care and treatment. We will look at those sorts of issues through the integrated care partnerships this year, next year and beyond in respect of Transforming Your Care. That is at the centre of what we are talking about.

Ms Gildernew: Ministerial priority and target 24 deals with children in care. I expected to see a nod to arrangements for looked-after children, such as kinship care. I notice that that is not in the draft plan. To what extent have the targets on looked-after children been influenced by the lack of progress on the Adoption Bill?

Mr Compton: I could not say that there is a disconnect between the two. Essentially, where kinship is important and there is an opportunity for that, we will always explore it. There is no issue with that. In fact, if you look at the total numbers, you will find that very large numbers of children are placed in what one would describe as a kinship arrangement. Target 24 is about avoiding placement movement, which we know is a particular difficulty for some youngsters who move from one place to another. It is about trying to keep that to an absolute minimum. So we will look to kinship care, foster care and to the minimal use of residential care, although, sometimes, that is appropriate or important.

There are other issues with adoption. It is a complex issue, and, from everybody's point of view, frustrating. It is a big step to say to natural parents that their child will be adopted by another family. You cannot do that lightly and without taking the appropriate legal course. We would like a simpler adoption arrangement. We hope to get that, because we would like it to happen more quickly. So although kinship care and the Bill are important and related, I am not sure that they are completely connected.

Mr Rooney: One of the indicators of performance direction relates to kinship care and others relate to adoption. As Catherine said earlier, the ministerial targets are intended to be few in number. There are only 29, so they are not meant to be exhaustive in all the areas that they cover. These are the areas for particular focus in this year's commissioning plan. However, we recognise that performance needs to be tracked and monitored in other important areas. The indicators of performance direction cover other areas that are not explicitly included in the commissioning plan targets.

Mr Compton: I want to reinforce that point. We cover the arrangements for how quickly children are seen in an emergency. There is a whole suite of targets associated with children that is not necessarily included in the detail of the indicators. We recognise the centrality of getting that into the right shape so that children are not left in any potential risk situation.

Ms Daly: I am conscious that we are talking about the establishment of some of the targets. The targets are set by the Minister. So that is really the Department's area, as opposed to John's, although John has clearly articulated why the levels are set as they are. We are due to meet the Committee again in a few weeks' time to discuss the indicators of performance direction, and, if it would be helpful, I think that we will be able to provide further detail on some of those issues then.

Ms Gildernew: I take that point, Catherine. Obviously, these are the Minister's targets. However, in respect of performance, it is up to you to deliver on them. My question was about the absence of the updated Adoption Bill. We all recognise that the legislation is very out of date. We are keen, as a Committee, to get sight of the Adoption Bill as soon as possible. Any further delay makes your position even more difficult.

Mr Compton: I accept that, and we would like the position to change. As you rightly point out, it is a complicated business, and this is one strand of it.

Ms Gildernew: We will, I hope, soon get to grips with the legislation on adoption and mental capacity. There is a bit of frustration about that at Committee level.

My last point is on priority 29, which relates to mental health:

"From April 2012, no patient waits longer than 9 weeks to access child and adolescent services or adult mental health services, and 13 weeks for psychological therapies (any age)."

Given the speedy deterioration of people in a very fragile state of mental health, does that not seem too long when we want people to be treated as early as possible to achieve the best outcomes?

Mr Compton: Yes, of course, but that is a ministerial target, and the process is the same as the one Dean outlined for the cancer target. It assumes referral and assessment, etc, so there is a suite of work and activity involved. Many people are seen much more promptly than is specified in the targets of nine weeks and 13 weeks. In Northern Ireland, we have difficulty in one area: child and adolescent mental health services (CAMHS). It remains a difficult issue, as you are probably aware. Our strategy is divided into four tiers of intervention, but CAMHS remains a challenge. It is a small service that deals with small numbers of very vulnerable youngsters and young teenagers. It is an important service, and we spend a lot of time talking to the providing trusts about it to make sure that we understand the issues and how those affect their ability to meet the targets.

Ms Gildernew: I was speaking to someone recently who said that moderate cases do not often get seen. There are ways of assessing how a pathway has been delivered. A young person often goes from having a moderate problem to having a severe problem very quickly, but statutory services do not often see young people with only moderate needs. It is one of those situations that seems to escalate and become very serious very quickly. Are enough resources being put into CAMHS to ensure that young people get the right quality of treatment?

Mr Compton: You are right to say that such problems can begin as not very serious but grow to become very serious within a short space of time, and our differing levels of intervention at tiers 1 to 4 reflect that. We are talking at length with the providing trusts about resources for that area. My colleague Fionnula McAndrew, the director of social care, regularly meets the executive directors of family and child care to look specifically at that problem. We have been working on a strategy to improve the availability of CAMHS services across the region.

It is not always a question of resources. Sometimes, skills issues are involved. We may have the resources, but we may not quite have the skills. It is a very challenging area of work, and not everyone wants to work in CAMHS. So there is a range of issues. I would not say for one minute that resources are not an issue; but they are absolutely not the only one. Other factors are the availability of skills and expertise and how the offering of those services is organised. We spend a lot of time talking to the providers to make that more straightforward.

Clearly, as was the case last year, when we come to talk about resource issues, it is not an area in which we will get into too much difficulty. We are likely to respond positively.

Mr McCarthy: Page 133 refers to a service redesign for community care and older people and the dementia strategy. What are your proposals for the provision of residential, nursing, and day care?

Mr Compton: Anyone with dementia will probably require some form of specialist support. First, we try to enable people to stay at home. When that does not work, it is important that people move to an environment that has the necessary skills to support and deal with the outworkings of dementia. It is more about specialist service provision as opposed to traditional residential care per se. I am on record as saying that we provide four types of care: care at home; residential care; nursing home care; and specialist care for dementia. The strategy is to provide specialist care when it is required, but to enable people to remain in or as close to their home for as long as is practicable, given the nature of the disorder. This year, when we look at our demography and invest in areas that tend to cater for older people, we expect to commit about £25 million across the region, and I am sure that a substantial proportion of that will go towards individuals with dementia, because they have the greatest need. I cannot give you a detailed split of funding, but I would be surprised if a large amount of the £25 million did not go to dementia.

Mr McCarthy: What about residential and day care? They are very important.

Mr Compton: They are. It is not that there is no demand for residential care, but it is decreasing, which is the natural consequence of being able to support people at home for longer through arrangements under housing with care. That reduction in demand is logical given the increased demand for nursing care and specialist dementia care. So we are signalling that change in the pattern of care over time.

Day care is part of respite care, which is an element of avoiding social isolation for older people and enabling them to remain at home, so it is important. The issue is how that will be delivered. Through Transforming Your Care, we talk about doing that in a locally sensitive way that reflects what is the local opportunity. That might mean, for example, working differently with local communities, the independent sector, the voluntary sector or the statutory sector. A major development is required to ensure that we have that access.

The Deputy Chairperson: In the absence of any other questions, thank you for coming. John and Catherine, you are here so regularly that I think that you must have season tickets for the Committee. I also thank Eugene and Dean for giving strong support. We will, of course, be watching with great interest to see how the implementation of the final commissioning plan develops over the year. We look forward to receiving the 2013-14 plan in the last week of March 2013.