Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Programme for Government Delivery Plans: DHSSPS Briefing

17 October 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)
Mr Roy Beggs
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr Conall McDevitt

Witnesses:

Ms Catherine Daly	Department of Health, Social Services and Public Safety
Ms Eilis McDaniel	Department of Health, Social Services and Public Safety
Dr Elizabeth Mitchell	Department of Health, Social Services and Public Safety
Ms Julie Thompson	Department of Health, Social Services and Public Safety

The Chairperson: I welcome — it is not very often that it is an all-female team. Last week we had the boy band on Transforming Your Care, so we have Girls Aloud this week. I welcome Julie, Catherine and Eilis and Elisabeth, who is still here. They are going to make a presentation before we open the floor for questions and comments.

Ms Julie Thompson (Department of Health, Social Services and Public Safety): Thank you, Chair, and thank you for the invitation to appear before the Committee to discuss progress being made against the Department's 2011-15 Programme for Government commitments. My colleagues with me today are Catherine Daly, the head of healthcare policy group, and she will lead on responses to questions about commitments 44,79 and 80; Dr Liz Mitchell, deputy chief medical officer, who will lead on commitments 22 and 45; and Eilis McDaniel, acting director of the childcare policy directorate, who will lead on commitment 61.

As you will be aware, the 2011-15 Programme for Government was agreed by the Executive and the Assembly in March 2012. The Department leads on six commitments, each of which has three milestones to be achieved at a rate of one a year from 2013-13 to 2014-15. The commitments and milestones are set out in annex A of members' briefing papers. Two relate to the public health agenda and obesity; one is focused on long-term chronic conditions; one on improving safeguarding outcomes for children and vulnerable adults; one on improving access to treatments and new services; and one on reforming the delivery of health and social care services to improve the quality of patient care.

In line with central frameworking guidance, the Department has developed a Programme for Government delivery plan for each commitment, the latest versions of which were sent to the Committee in advance of today's evidence session. Each delivery plan is owned by a senior responsible officer in the Department. They are living documents, and they are continuously updated throughout the process, although there is no intention to amend either the milestones or the commitments.

The Office of the First Minister and deputy First Minister (OFMDFM) has recently requested quarter 2 (Q2) progress reports for each of the Department's six commitments covering the period up to September 2012. The position that we have reported back to them and are reporting to the Committee is that we are on track for five of our six commitments and broadly on track for one — commitment 44 — on long-term chronic conditions. The Department remains confident that this commitment will be back on track for delivery by the end of year 1. Delivery has been temporarily hindered by resources having to be diverted to work on Transforming Your Care, but we are confident that that is a temporary issue that we will be able to resolve.

We are, of course, monitoring the progress of all our commitments and milestones through our normal business planning, monitoring and reporting processes, and that includes regular reports to the departmental board and the Minister. Delivery of the commitments and milestones also requires actions by a number of our arm's-length bodies (ALBs), principally the Health and Social Care Board and the Public Health Agency, and we have been working closely with them to ensure that they are in a position to deliver on the Programme for Government. We have taken steps to ensure that Programme for Government commitments are an integral part of all our planning processes, for example, through the commissioning plan direction, and we will continue to monitor progress through our ALB accountability arrangements. Delivery against our Programme for Government requirements will also be addressed explicitly as part of the mid-year accountability meetings with all ALBs. Formal progress against the delivery of Programme for Government commitments is also being monitored by a central Programme for Government team in OFMDFM. My colleagues and I are more than willing to answer any specific questions that you may have.

The Chairperson: Thank you. That was a lot of information. We criticise you one week for not giving us information, and, when you give us information, we criticise you. It is quite useful; thanks for that.

You said that, in general, the Department leads on programmes. That is fair enough; it is what you do as a Department. The Department is also involved in ministerial subgroups, although you might not have the lead on them. Can you give us a wee rundown of those, and I will then get into the specifics of this?

Ms Thompson: We had the lead on those six. Each Programme for Government commitment has been given to an individual Department. There is a ministerial subgroup on public health, and maybe Liz will talk about that aspect. We need to feed into a range of other commitments in other Departments, whether they are to do with childcare or the economy. Liz, do you want to talk about public health?

Dr Elizabeth Mitchell (Department of Health, Social Services and Public Safety): Two come to mind: one is our ministerial subgroup on public health, which, as you know, oversees the development of the public health strategic framework and, previously`, Investing for Health; and our Minister also chairs the ministerial co-ordination group on suicide prevention. Those are the two that I am involved in. We have other interdepartmental groups, Sue, with representation from other Departments but not necessarily at ministerial level.

Ms Catherine Daly (Department of Health, Social Services and Public Safety): There are other ministerial groups that our Minister may not be a member of but certainly contributes to. For example, the economic subgroup is very important in the context of health, and the Health Department makes a big contribution to that. The Minister attends that when required.

The Chairperson: I am glad that you mentioned public health because we are looking at health inequalities, and one issue is how we can utilise the public health agenda to target health inequalities in general. We got information from the Minister — you have probably not seen the letter — showing a breakdown of the Programme for Government commitments to invest an additional £10 million in public health. The public health spend is close to £78 million, but the Public Health Agency gives close to £10 million to the Belfast Trust; close to £3 million to the South Eastern Trust; close to £4

million to the Southern Trust; just under £5·5 million to the Northern Trust; just over £5 million to the Western Trust; and £47,000 to the Ambulance Service.

You might not have all the detail on that but, if we have a public health agenda and a Public Health Agency that, in my view, does not get enough money to deal with prevention and the issues associated with ill health, why is it giving the trusts money? You might have to come back to me in writing. Eilis is well aware that I had difficulties with the programme funds, because the children and young people programme fund was supposed to be additional money for communities to target specifics. Roy was on the all-party group at the time with me. However, the money was never seen as additional.Some of the boards and trusts were applying for the money and delivering programmes that they should have delivered in the first instance, so it was never additional in the communities. I could be wrong, but I have the same concern here. If the Public Health Agency has a budget of just under £78 million and it then spends just over £50 million, but the rest goes into the trusts — for what reason?

Dr Mitchell: There are some things that are included in the Public Health Agency budget that only trusts can deliver. That includes screening programmes. It gives between £7 million and £9 million to the trusts to implement those programmes, such as the bowel cancer screening programme, breast cancer screening and a number of other screening programmes.

Money is also given for health improvement through quality of services in relation to healthcare-acquired infections and general standards of nursing and quality in wards. Also, there is work on telehealth. Around £4 million or £5 million goes to the trusts for that. The trusts also do work on breastfeeding, smoking cessation and obesity management — health improvement programmes — and about £4·8 million or £5 million goes to the trusts for those. And then there is some help with immunisation programmes, which is about £1 million.

Therefore, in a number of areas, the money is directed through the trusts, but it comes through the PHA, and that helps us to monitor it. Some of that does not end up in programme of care 8. When the trusts go back and apportion it, it ends up in, for example, suicide prevention, on which the trusts do a lot of work in delivering services, and on mental health promotion. That goes into programme of care 5.

Around £15 million of the Public Health Agency's money goes to organisations in the community and voluntary sector to deliver services. About £500,000 goes to local government, and some money is held centrally; for example, the money for the advertising campaigns and some money for the smoking cessation services that are delivered through a range of different providers in communities. Some things like purchasing flu vaccine and so on come out of that budget. Some services are delivered through trusts, and the important thing is that we can monitor that through the Public Health Agency.

Of course, money is only part of it. It is also about looking at the programmes that the trusts deliver and how they are helping to improve and narrow health inequalities.

The Chairperson: Will you give us a breakdown of exactly what that is in the trusts so that we have an idea? I know what you have covered, and that settles me a bit, but it is just so that we can analyse that a wee bit further.

Dr Mitchell: I will liaise with Julie in trying to give you that in a comprehensible and comprehensive breakdown.

The Chairperson: You see the Programme for Government itself, and the targets? At times, the Department has set itself targets to achieve etc, etc. On the issue of A&E and patients attending type 1, 2 or 3 A&E, I know they are talking about being either treated or discharged home or admitted within four hours. At times, that target has not been met. So, are we saying that, in the next year, there will be a target of 1% of patients breaking that waiting time, or is there just a general view that we will be working towards that?

Ms Daly: Each year, Chair, we review the targets that are in the commissioning plan direction against what the performance has been in the previous period. The targets are set on the basis that they are intended to be stretching but realistic and deliverable. It is certainly not the intention to move away from that target. You will be aware of all of the work that has been taken forward under the improvement action group, led by Mary Hinds. That is very much focused on the 12-hour breach, because there are different dimensions in emergency care. When we are developing this, which we

are in the process of doing now, we will look at whether there are ways that targets can be made more meaningful. Perhaps there is a disaggregation of information that will be more helpful to the Minister when informing the public about what exactly is happening at emergency departments.

The Chairperson: I take it that you are not suggesting that there will be targets only when you know that you can achieve them?

Ms Daly: No, not at all.

The Chairperson: There are targets in the commissioning plan, but some targets are not in the delivery plan. It makes you feel as if —

Ms Daly: In the Programme for Government delivery plan?

The Chairperson: Yes.

Ms Daly: Absolutely. The targets in this specifically relate to the commitments in the Programme for Government. Those commitments do not cover the full scale of everything that is being taken forward in the Department.

We have the Programme for Government. Below that, there is the commissioning plan, which sets out the commissioning intentions for the Health and Social Care Board in response to the Minister's commissioning plan direction. There is a whole infrastructure of different elements that contributes to everything that is taken forward in the Department and by the board and the trusts. The fact that it is not in this document means it simply is not highlighted as one of the commitments. It certainly is a commitment for the Minister, and it is reflected in his commissioning plan.

The Chairperson: There are certain targets in certain documents and then they are not in, and then there are targets in some of them and not in others. It seems that targets are set —

Ms Thompson: The templates reflect the Programme for Government commitments and the indicators that support them. You are quite right: they do not cover all the targets and indicators that the Department monitors, which are, in the main, picked up through the commissioning plan direction and the monitoring of that.

Ms Daly: To elaborate on that a wee bit, the Minister issues a commissioning plan direction each year to the board and Public Health Agency. Behind that, there is also an indicators of performance direction, which has a number of indicators of performance. Not only are those targets there, but there are indicators of performance that we look to the board to monitor in terms of how they relate to the specific targets. Behind targets, there are indicators of performance. There is quite a detailed level of monitoring in that whole performance measurement against those targets.

I appreciate what you are saying: there are different documents. It is just understanding how all of them align, because they do.

The Chairperson: I try not to be cynical all the time. Are you only putting in targets that you know that you can meet?

Ms Daly: Absolutely not. It is really important to be very clear about that.

The Chairperson: Considering that the Programme for Government is a published document and considering some of the stuff that we got, it does not make sense that there are some targets in the public document and no targets in the delivery end of it. Convince me that nothing else is happening and that you will meet those targets.

Ms Thompson: The commitments in the Programme for Government and the indicators in the delivery plan documents that you are talking about are all mapped around the commitments and milestones as part of the Programme for Government. They are all signed off and agreed at Executive and Assembly level. There is certainly a complete cross-match from the Programme for Government into those delivery plan templates. That is what they are designed to do. Every Department has them. They are established by the Office of the First Minister and deputy First

Minister (OFMDFM) as a mechanism of ensuring that the Programme for Government is delivered. That works across everybody. As Catherine described, we have our —

The Chairperson: Next time, maybe you will put the same targets in these so that it convinces us that there are targets.

Ms Daly: The ones that I am the senior responsible officer (SRO) for are commitments 44, 79 and 80. Some of those are in the commissioning plan direction as targets, and there are indicators of performance also. It would probably be useful if we compile something that shows how all of those align. However, it must be realised that they are not the same documents; you will not get everything in the Programme for Government that you will get in the direction.

The Chairperson: OK. I have a question for Eilis as well.

Ms Thompson: As part of the work on the public health strategic framework, we are doing work on developing our sets of indicators, the trajectories for those and what we hope to achieve. We are trying to complete that piece of work by December so that we will have it when we launch the new public health scheme. The templates are live documents. We will feed that into those once we have done that work.

The Chairperson: I want to touch on the Mental Capacity Bill, and then I have a couple of questions for Eilis. Other members want to ask questions also.

On page 93 of our stuff, point 5 refers to the Mental Capacity Bill. The probability of risk occurring is on a scale of one to five, and it is down here as a four. What does that mean? That refers to commitment 61.

Ms Eilis McDaniel (Department of Health, Social Services and Public Safety): What part of the document are you referring to, Sue?

The Chairperson: The at-risk register. It is at page 14, number 61.

Ms McDaniel: What you have got described there is the possibility of our not being able to bring forward a piece of mental capacity legislation, and the impact that that would have. A fairly high level of risk is reflected in that scoring.

The Chairperson: A risk of its not coming forward in this mandate?

Ms McDaniel: Yes. The risk is a result of the introduction of criminal justice elements to the Bill. However, if everything is going according to plan, the criminal justice policy bits of the Bill are being consulted on; a consultation document was apparently released in July.

The Chairperson: You appreciate that this is my own view, Eilis, but that is the first that we have heard of it. We have been doing a bit of work around the Mental Capacity Bill; we are preparing for it, and the information received from the Department is that there is a probability that it might not come up. Sometimes, it would be useful to let the Committee know as well, sooner rather than later.

Ms McDaniel: The intention is to introduce a Bill to the Assembly late in 2013, and, if everything goes according to plan, that is exactly what will happen. The civil bits of the Bill, if I can put it that way — the instructions to counsel, etc — are being progressed at the minute. I think the real risk comes from the criminal justice elements to the Bill, but assuming that everything goes according to plan, the Bill will be introduced next year.

The Chairperson: I am just flagging that, because the Deputy Chair and I and the Chair and Deputy Chair of the Justice Committee met both Ministers some months ago. We have been teasing out how to take this forward, and then this in front of us indicates that, in all probability, it might not even be introduced. I am not saying that it will not be introduced, but we need to know about that issue.

Ms McDaniel: OK.

Ms Thompson: We can come back and confirm that risk level as well when we do the next update for the next time, and just confirm that it is an up-to-date reflection on the probabilities.

The Chairperson: Eilis, I am glad you are here. I know that, in Transforming Your Care, there is a whole vision of closing or downsizing residential adult care, and that stuff; is there anything specific about children in care, around moving people out of those types of home settings into —

Ms McDaniel: That is certainly not our current policy position. Our position is that there will always be a need for residential care for children. For some children, fostering is a suitable option, but for others, particularly those with more complex needs, I think there will always be a need for children's residential care. What is happening in more recent years is that older children are entering residential care, so our current policy position is that, where there is a need for residential care, we will continue to provide it for children. Our expectation is that that need will always exist, based on the nature of the complexity of the problems that the children have been experiencing in recent years.

Mr Gardiner: When you talk about the older person going into care, what age group are you speaking of?

Ms McDaniel: Fifteen-, 16- and 17-year-olds. We are talking about children in the later teens.

Mr McCarthy: To follow on from your question on the Mental Capacity Bill; that information is a bombshell to me. We were led to believe that this was progressing smoothly, and I hope that it will, because it is a landmark Bill. It is a world leader in that the mental capacity legislation is coming through together, and it would be a disaster if something somewhere down the line was preventing it. Can the Department give details on the obstacles preventing — you may have mentioned it to the Chair — the completion of the legislation within this mandate? That is very important. What are your plans to resolve those difficulties? We should all make a determined effort to ensure that it passes through the Assembly during the current mandate.

Ms McDaniel: My understanding is that we are on track. The Department of Health is certainly on track. Instructions to counsel are being drafted at the minute. We should have a draft Bill by spring next year, and we will consult on that over the summer months. The intention is to introduce it late next year. There might be an issue around how the level of risk associated with the Bill is represented in the documentation. As Julie said, we need to reflect on that, and there may be some alteration to the level of risk as presented in that documentation.

Mr McCarthy: We also think about Bamford and how it is behind, really, and it is so important that we move together to get this through. How can you keep us informed about the progress or otherwise? We do not want to see or hear any reports that, for some reason or other, it is not going to go. How can we be kept abreast of what is happening?

Ms McDaniel: This is not my policy responsibility, is the first thing that I will say. I am not wiping my hands of it, but I need to speak to the policy lead to see why that level of risk is reflected in that document in that way.

Mr McCarthy: That is exactly the crux of the matter. If we can get over that, we can make progress. As far as I and this Committee are concerned, this is a landmark Bill. If the two Departments work together, we can be a world leader. Let us do everything that we can to make progress on it.

Ms Thompson: If it is helpful, we can come back to the Committee on that immediately rather than wait until the next quarter. If that is what you would like us to do, I am happy to do so.

Mr Wells: What about the process? Have we, as a Committee, or the Justice Committee, been made aware of any of this?

The Chairperson: No.

Mr Wells: So, it has literally come in today. I serve on both Committees, and both are gearing up for a major piece of work in the next couple of months.

The Chairperson: I was up late reading my papers.

Mr Wells: I would have thought that that would be protocol for such an important potential change in the circumstances because, as little as two weeks ago, I got an assurance that that is definitely coming.

Ms Thompson: The issue is about the documents in front of you rather than the Mental Health Capacity Bill itself. Given the concerns that have been raised, we will come to back to confirm that all is on track.

Mr McDevitt: I have a technical question for Julie. The overall figures, the sort of headline figures, are all projected figures, correct? When we look at 2012-13, 2013-14 and 2014-15 —

Ms Thompson: Are you looking at a particular —

Mr McDevitt: I am looking at version 2.0, commitment 22, which is to allocate an increasing percentage of the overall health budget to public health. Overleaf from that, it tells us what the —

Ms Thompson: Yes, those are projections.

Mr McDevitt: OK. Just to ask the question we were debating a question a couple of weeks ago, are those figures half of what we will actually end up spending on public health, or are they what we will end up spending on public health, or what are they?

Ms Thompson: They are the spend through the Public Health Agency, and, therefore, we anticipate that those amounts will be the actual spend. We do not expect the difficulties that you are describing from a couple of weeks ago with those amounts. It is clear and very transparent, and those amounts will actually be audited in the accounts. The Committee can have full assurance that that is our prediction of where those amounts will go and that is what needs to happen to get to the extra £10 million.

Mr McDevitt: So, we can say with confidence that, as a percentage of the health and social care budget — rather than the DHSSPS budget, which might be a bit unfair, given that social care is lumped in there — public health will be 1·79%, which is 18p out of a tenner this year. It will then be 1·87% in 2012-13, 1·87% in 2013-14 and 1·9% in 2014-15.

The Chairperson: Conall, if you highlight the page —

Mr McDevitt: Sorry, it is on page 34 in our briefing pack, Chair.

The Chairperson: What is the page number at the bottom?

Mr McDevitt: And that is page 15 in the brief provided by the Department. So it is basically running at about 18p out of every £10 at the moment in public health, and we are going to get up to the spectacular high of 19p in every tenner in public health.

Ms Thompson: The milestone agreed in the Programme for Government is to invest an extra £10 million into the public health agenda, and that is what that reflects as a percentage. The £10 million goes in, which increases it from £77 million to £87 million. That is what is agreed as the third-year milestone for that particular commitment.

Mr McDevitt: Out of a budget of £4·659 billion.

Ms Thompson: Liz can maybe come in here. You are right to look at the whole budget and what more can be done around public health, but the particular commitment of this milestone is to ensure that that £10 million goes in by year 3.

Mr McDevitt: Do you know what the average spend on public health in Organisation for Economic Co-operation and Development (OECD) countries is?

Dr Mitchell: We tried to get some information on that for the review and for Investing for Health, but it is very hard to know that people are counting the same things. We looked at somewhere like Australia, and, if my memory serves me, I think it was around 4%. But again, what budget are you comparing it with? It is very difficult. I think —

Mr McDevitt: Let us compare it with the HSC budget, because that is —

Dr Mitchell: Exactly. The key point that I agree with you on is that this should not be the totality of what we are spending on prevention, early intervention and public health. This is a pot that we can monitor and closely watch to make sure that we are putting it into evidence-based interventions. However, we need to make sure — and it is part of the whole system thing of trying to make a shift to the left through Transforming your Care — that, with every pound that we are spending, we are trying to spend more on prevention, early intervention and detection and screening — all those things — and, indeed, moving people out into the community. Unless we try to influence that in the £4 billion, this is a very small amount, but the important thing is that we can focus on this, make sure that it is going on evidence-based programmes and monitor it clearly. It is important, against a background of all of the constraints on the budget, that we are protecting that money for public health.

Mr McDevitt: It is relative protection, because you are able to guarantee us that the Public Health Agency — the poor sods — will not spend a penny more than it has been allocated, but then, it seems that the projected figures everywhere else in the NHS are just that, projected figures, and the out-turns are invariably 15%, 20%, 22% or 23% above. That is just an observation.

The average OECD expenditure in public health is actually 2·8%, and no one seems to quibble about that. I have not seen any huge disclaimer. I checked it there while you were making your introductory remarks. So, 2·8% is still only 28p in a tenner, and we are going to get to 19p. That is the average for the OECD, so we are going to be spending a little over half of what the average OECD expenditure is going to be at the end of this cycle.

Dr Mitchell: What we are saying is that some of the money that goes on public health and early intervention, which may be counted in other places, is buried within that £4 billion. This is the bit that we can clearly and transparently audit, track and monitor. It is not the totality of money that is going into public health, early detection, prevention, etc. I know that it does not include what is happening in the family practitioner services, for example.

Mr McDevitt: How much is going into public health?

Dr Mitchell: I would have to come back to Julie on that.

Mr McDevitt: If you cannot tell me what is not, tell me exactly how much is.

Ms Thompson: The basis that we talked about before, around programme of care 8 and health promotion, is, I guess, the closest answer to that. That was around £109 million, as we debated a couple of weeks ago when I was here. That is picking up a range of other issues, as Liz has already said, that are actually going through individual trusts. The baseline that has been used here is the Public Health Agency spend, for the straightforward reason that we can actually control that. That is where the money is going in, and we can actually see and reflect that through the programmes as they go through.

Mr McDevitt: I will not go on much longer, but it is worth noting that, even if you did take the £109 million that we discussed, you would still be miles off the OECD average, and that is lobbing everything that you can possibly think of in. That was your best guess a couple of weeks ago when we took everything. We took it from every bit of the health service budget that even hinted that it was doing something preventative, and we were able to get it up to about £109 million. If £87·2 million is 1·9%, that would maybe take you to 2·1% or 2·2%. It is miles off the average, never mind best practice, and we hold this place up to be a model?

Ms Thompson: It does not include primary care, and we need to understand whether the OECD numbers include the primary care element of the system as well.

Mr McDevitt: They do not, in fact. I checked that. My question is the question that the Chair asked. Are these real? Frankly, we know how much it costs to run the Public Health Agency, but it is not

credible to make a Programme for Government commitment that is so far off any of the international benchmarks that we consider ourselves to be operating within and to say that meeting it is a success. It is not. It is an abject failure. We are miles behind every other OECD country that we consider to be comparable with us. It puts us down in the bottom quartile of all OECD countries, and that includes countries that are 20% and 30% below where we are on the development index.

Ms Daly: Looking at the figures in isolation can be misleading. As Julie and Liz said, there is a specific target in the PFG that is not about the whole of public health but about that additional funding that is going in.

Mr McDevitt: You talked about the whole of public health earlier.

Ms Daly: OK, but the whole health and social care service is very complex, and the direction is very much strategically in the context of prevention and early intervention. Carrying out an analysis of that budget would get a figure that is much more realistic in terms of the total contribution to the public health agenda. Liz and Julie have highlighted some of the facts about comparing like with like, and, on the face of it, comparing a figure of 2·8% with the figures that are mentioned here makes it look as though there is a big disparity. However, there really is an important thing about ensuring that the comparison is on a like-for-like basis.

Mr McDevitt: The other way to look at this is to look at the outputs. I could take it that we did not need to invest an awful lot if we did not have one of the highest instances of obesity in western Europe, if our cardiac disease rates were not higher than most other parts of the world, if our type 2 diabetes rate was not increasing at a higher rate than in most other jurisdictions and if the prevalence of certain types of cancer was not much higher here. If I thought that we were a really healthy society with no big acquired condition problems, I could accept this, but the opposite is true. Therefore, I think that this says it all about where the priority is in the Department of Health. I have to be honest with you, and I think that we like to talk and come in here and champion the fact that we are putting public health first, but there is no evidence of it in terms of output, and certainly not in terms of investment.

Dr Mitchell: One of the other points I wold want to make, Conall, is that it is not just about what the health service is spending. It is about what other Departments are doing, the wider determinants of health and the whole Executive pulling together. That is where the Programme for Government comes in. It is a mistake to think that the health service and the Department of Health can do this on their own. They cannot.

Mr McDevitt: I agree.

The Chairperson: *[Inaudible.]* Public Health Agency and prevention and tackling health inequalities. It might make it easier for us, because we are trying to go through every pound that is spent in the Department, and by the Department, and by bodies that are associated with the Department, and we still cannot get to the bottom of it. As much information — and we have asked for this as well — as is given to us would make it easier on the stuff that you are saying. Social care is complex, but, when we are being told by the board than £10 million is being spent daily but that we do not know what it is being spent on, you can understand why members come back with questions.

Mr Dunne: I must say, the delivery plan is complex. I have not fully studied it, to be perfectly honest. Commitment 80, on page 125, jumps out somewhat. It is to reconfigure, reform and modernise the delivery of health and social care services, and we are all keen on that. Are your documents numbered differently?

Ms Thompson: Are you focusing on a particular page on commitment 80?

The Chairperson: It is page 2.

Mr Dunne: Page 2, yes. I was just talking about the heading for commitment 80. I take it that that aligns quite a bit with Transforming Your Care, on which we have been very well briefed.

Ms Daly: Yes, absolutely.

Mr Dunne: How do you monitor progress on Transforming Your Care against commitment 80?

Ms Daly: In that commitment, there are specific targets that are required to be delivered. In taking forward the whole Transforming Your Care agenda, key milestones were set out to begin with, such as the development of the population plans and the strategic investment plan and then the consultation process, which is moving forward.

Behind all of that, both in the Department and the Board, there is a governance structure that is monitoring that progress to ensure that the relevant specified targets are delivered. Once the consultation is completed and the Minister takes his decisions on the way forward, further targets will be developed, and they will be monitored through the strategic planning group in the Department, which is chaired by the permanent secretary and reports to the Minister. Within that, there is representation from the transformation programme board, which is chaired by the chief executive of the Health and Social Care Board. He is also a member of that strategic planning group. Outside that, there is an expert panel that provides advice to the transformation programme board and an advisory panel that provides advice and a challenge function to the strategic planning group.

So, the governance structure around that is complex but comprehensive. It is absolutely critical that, as we move forward, it is possible to deliver the change that that whole shift left within the existing resources that have been made available to the Department. So, it is absolutely critical that we are close to that and monitor that progress.

Mr Dunne: So, you are monitoring that. Your figures reflect the progress of Transforming Your Care. Is that a fair comment?

Ms Daly: That is right.

Mr Dunne: Of your performance indicators on commitment 80, the big one is about waiting times in A&E. How are those figures working out for this year? We are just over six months into 2012-13. Do you have any indicators?

Ms Daly: I do not have the up-to-date figures with me for the four-hour target, but I think that we are all clear that that is an area where there is still concern. The trusts are not delivering on the 95% target. Work is ongoing. I mentioned the improvement action group, and work is ongoing through that group to address issues in emergency departments and look at lessons that can be learned from good practice across the trusts. That is something that was picked up on by the Committee when we were here before. Under the improvement action group, the Health and Social Care Board is holding a seminar later this month for all trusts to identify processes of good practice and examples and learning that can be shared. That applies to trusts in Northern Ireland and includes the experience in NHS trusts.

At this point, we are not on target with the four hours, and we are continuing to work on it. We look to the board to ensure that it is holding the trust to account and performance managing people to deliver on that target. It should be taking action where necessary so that there is progress on the delivery of that target.

Mr Dunne: The Minister is keen on the 95% target.

Ms Daly: Very much so. He is absolutely committed to it.

Mr Dunne: Is that a priority? Does the fact that it is "Indicator 1" mean that it is a priority?

Ms Daly: No, they are not necessarily in priority order, but it certainly is a priority, and it is something that the Minister has been very focused on. He has been very public about his concerns and that focus continues, as does the work.

Mr Dunne: Thanks very much.

Ms Maeve McLaughlin: I do not think that it is necessarily accurate, when we are asking about accurate spend or accurate figures, to say that it is somehow somebody else's responsibility. Ultimately, the Department has signed up to six commitments. My reading of this is that five of them are on track and one is not, and that is the commitment to enrol people with a long-term chronic condition on a dedicated condition management programme. In my limited understanding, that does

not seem to be a particularly difficult target to reach. Is there any rationale as to why that has not progressed?

Ms Daly: It has progressed. The reason for the delay in progress — we would have expected it to move faster — was quite simply work pressures. Although I say "quite simply", this is a very important target and a very important commitment. The Department faces significant pressures this year in taking forward the whole Transforming Your Care process, and these fall within the same policy area, but we have taken action in the Department to ensure that resources are addressing specific elements of this commitment. That is moving forward now, and significant work has been done between the Department and the Public Health Agency in developing questionnaires to go out to trusts so that we can clearly establish that education baseline. I expect that, when we report on this in the next quarter, it will be a "green" commitment.

Ms Maeve McLaughlin: So, we do not have the data set together at this point.

Ms Daly: No, we do not, but that is what we are working on.

Ms Maeve McLaughlin: OK. It has to be said, particularly in regard to the public health agenda and the commitment to reallocate and increase the allocation towards public health, that we do not have any performance indicators, despite what you said — and I listened very carefully to what you said — about there being different commitments under different aspects of what you deliver. I think it is critical that we get those performance indicators so that we can engage, monitor, challenge or support what is happening here. They are simply not there.

The Mental Capacity Bill was mentioned, so I will not talk specifically about it. You referenced a strategic framework, and that work is critical if we are to tackle the health inequalities that exist, as the Chair said. If Transforming Your Care is to do anything, it has to be outcome-based. What stage is that strategic framework at? Could you update us?

Dr Mitchell: Yes, the public health framework document, 'Fit and Well', went out for consultation in July. The consultation period closes at the end of October, but the Minister gave an undertaking to the Health Committee that he would delay publication so that we could, as part of the consultation, take into account your health inequalities work and report when producing the final document. I also mentioned that, as part of that work, we are developing a set of indicators that will underpin and support that, and that will feed into the monitoring of the Programme for Government.

Ms Maeve McLaughlin: Just to be clear, I am referencing page 2 of your paper, which states:

"Work is underway to develop a new strategic framework".

Is that what you are referring to?

Dr Mitchell: Yes.

Ms Maeve McLaughlin: OK. You have clarified that. Thank you.

Mr Beggs: I am quite interested in how your milestones were arrived at. One of your objectives in the Programme for Government is to invest £7·2 million in programmes to tackle obesity. The milestone seems to be all about spending money as opposed to what the outcomes are. I do not think that is a healthy milestone to have. It is quite easy to spend the money as opposed to achieving something by doing so. The first milestone is to invest £2 million, and the second is to invest £2·4 million. It is quite easy to achieve those milestones. Do you think it would be worthwhile to reflect on that so that more constructive targets can be put in place?

Dr Mitchell: Again, we have an obesity prevention framework, Fitter Futures, which was published within the past few months. Work is ongoing. There is a steering group meeting next week at which the implementation plan will be looked at, and that is where the detail will be worked out around which programmes the money will be spent on and what outcomes we want to monitor. So, all of that is work in progress. At the time the Programme for Government commitments were made, the obesity framework had not been published and the implementation plan had not been developed, so we were not in a position to fill in all those other things that we would have liked to have filled in. Again, they will be added as we develop those.

Mr Beggs: I agree with you. When I look at the key actions for delivery on pages 69 to 71 of the document, I see that it is all about developing steering groups, action plans and business plans with trusts and boards, yet I do not see anything being done. So, I am certainly looking forward to something more constructive or concrete coming out of it.

Dr Mitchell: We have indicators that look at the levels of obesity in adults and children, and we have targets in our obesity framework to reduce those. As for the work on obesity that is currently going on, which we hope to increase, we can divide that into what we are doing on physical activity and nutrition and, in respect of secondary prevention, where people already have established weight problems, what we are doing on weight management. We also have ongoing work on monitoring and establishing the database and research to underpin that. We are doing a lot of work with schools, the Department of Culture, Arts and Leisure (DCAL) and Sport NI to promote physical activity. We are not just using that as a means of tackling obesity; it is effective against a range of health problems and mental health issues. Some very important things are going on in respect of exercise, referral schemes and work to target pregnant women who have an obesity problem. We are thinking about what we can do with those groups and what more we can do with children to prevent obesity from developing early in life. So, a lot of work is in train and developing around that.

Ms Thompson: To go back to the start of this afternoon's discussion, those indicators are picked up through the commissioning plan direction as well. There is a focus on moving that towards a more outcome-based planning direction. So, it will be picked up there, too.

Mr Beggs: Commitment 80 is about modernising the delivery of health and social care services. One of the key milestones is to reduce excess bed days. My grandfather was in hospital and was ready to get out, but the consultant was on holidays. I know that things have been changed to bring about improvements, but I am conscious that there seems to be a big push to get people out of hospital, and rightly so — we want to ensure that people are treated and are able to return to a normal situation as soon as possible. I understand that, but the bit that I do not see in the programme is the balance. I have also seen elderly extended family members being moved out of hospital before they were ready to leave and before they were rehabilitated, which resulted in readmissions. You indicated that you are trying to avoid readmissions, but I have not seen that being used as an indicator. Should you not use the number of readmissions as an indicator? Aside from avoiding trauma for the individuals involved, you need to make sure that the policies do not drive too far in one direction and that they do not start to create significant additional costs.

Ms Daly: I will try to pick up on all of those points. Certainly, the reduction in excess bed days is in line with the whole shift from secondary care to primary and community care under Transforming Your Care. Various elements of the whole Transforming Your Care proposals come together, which should ensure that there are safe and sustainable services so that people get the right service in the right place. That means that, if someone comes out of hospital and goes to their home, which is the hub of where care will be, services will be available.

You mentioned the indicators. It goes back to the link between the Programme for Government commitments and the indicators of performance direction under the commissioning plan. There is a performance indicator in that on readmissions. As Julie said earlier, this is a living document. We are learning as we are going through this about what the right information is and what we should be monitoring to ensure delivery. We will look at all this as we go forward. So, absolutely, I take your point on the readmissions. It is in the indicators of performance under the commissioning plan, and we perhaps need to look at including it here.

Mr Beggs: I have had recent experience of the issue with extended family members. One had no mobility and ultimately went back for rehabilitation in a nursing home, which is one of the homes earmarked for closure. When that person was discharged from hospital, there was very weak rehabilitation, and I have a genuine fear that it was about releasing the bed to take the pressure off the other hospital and to keep the flow going. That is an important factor, but it is also important to ensure that patients are rehabilitated and able to sustain themselves in their home. Another family member ultimately had to be readmitted through a GP and accident and emergency, again, because of being discharged too early. There has to be a balance in this, and I ask you to ensure that that is the case.

Ms Thompson: I reassure you that there is a commissioning plan direction target to secure a 10% reduction in emergency readmissions by March 2013. That will pick up exactly the point that you are making.

Mr Beggs: That is good.

The Chairperson: OK. That is it. You need to provide information to us, but, on behalf of the Committee, I thank you very much for the information that you provided and for your presentation.