Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2014: DHSSPS Briefing

23 October 2013

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Ms Catherine Daly	Department of Health, Social Services and Public Safety
Ms Jennifer Mooney	Department of Health, Social Services and Public Safety
Ms Julie Thompson	Department of Health, Social Services and Public Safety

The Chairperson: OK, folks. You are very welcome. We will move straight in to the presentation and then open up the floor to members.

Ms Catherine Daly (Department of Health, Social Services and Public Safety): Thanks very much, Chair. I am Catherine Daly from the Department. With me here are Julie Thompson, senior finance director in the Department; and Jennifer Mooney from the Department's transformation directorate. We are very grateful to the Committee for the opportunity to brief you today on the draft commissioning plan direction for 2014-15. If you are happy, what I will do is outline the background to the development of the direction and highlight the key elements. We will then be happy to take any questions that the Committee has.

The commissioning plan direction is intended to set out the focus for the Regional Health and Social Care Board and the Public Health Agency in the commissioning of health and social care services for the forthcoming year. The direction is a requirement under the Health and Social Care (Reform) Act (Northern Ireland) 2009, and in line with section 8(3) of the Act, the board is required to prepare and publish a commissioning plan each financial year after consultation with the Public Health Agency, setting out such details as the Department may direct, and thus the board must produce a commissioning plan in line with the direction set by the Minister and do so in agreement with the Public Health Agency. So, the commissioning plan direction is the first stage in that commissioning planning process.

The commissioning plan needs to set out details of the services to be commissioned in the financial year to which the plan relates, as well as details of the cost to be incurred in that regard. The direction

communicates the Minister's overarching strategic priorities as well as the specific standards and targets for the health and social care sector. It also specifies the required form and core requirements of the commissioning plan. In response to that, the plan must detail how the services commissioned will deliver on those priorities and objectives. It is important to highlight that the standards and targets that are set out in the schedule to the commissioning plan direction are only one element of the direction. They represent a relatively small number of areas that should have a particular focus in the coming years so that performance is maintained and improved in those areas as appropriate. Those areas are highlighted in the direction, but there are, of course, other important areas across the full range of health and social care services to be delivered to support the Minister's strategic priorities.

The full alignment of business planning and financial planning in the integration of transformation, in response to Transforming Your Care, into mainstream planning is essential to have effective delivery of services with existing resources. In that respect, the commissioning plan for 2014-15 should integrate the planning elements for commissioning, finance and transformation into one integrated document. That should include the services to be commissioned, the underpinning financial plan and the ways in which commissioning will deliver the planned transformation. It is proposed that the commissioning plan will detail the commissioning intentions and financial commitments for 2014-15 and should provide indicative commissioning intentions and indicative financial commitments for 2015-16. That detail is required at regional and local commissioning group level, and it is intended to ensure that the plan reflects the implementation of planned services and transformation over the longer planning period — so, a period of more than just one year, as has been the case to date.

Local commissioning groups have a lead role to play in the commissioning process in assessing the health and social care needs of their local populations, planning to meet the current and emerging needs, and securing the delivery of a comprehensive range of services to meet the needs of those local populations. The overall commissioning plan will, therefore, include the five local commissioning group plans.

In developing the direction, we have already engaged with the Health and Social Care Board, the Public Health Agency, the trusts, local commissioning groups and the Patient and Client Council just to take their views and comments on the content of the direction. I am very grateful to be here today to take the Committee's views and comments.

The time for this process is extremely tight. It is important that the commissioning plan is prepared on a timely basis. In that respect, it is important that the various stages in the development of the plan are completed on a timely basis to ensure that the plan is agreed, ready and approved before the beginning of the financial year to which it relates. The planning process has improved significantly over the past couple of years, and it is our intention to try to maintain and improve on that timeline.

The direction is still in draft form, and, therefore, it is subject to further change. In that respect, members will note that there are a small number of targets and standards for which specific levels have not yet been agreed. However, we are continuing to work with colleagues across the Department and the other organisations to develop those.

It is important that the commissioning plan aligns with and provides details of how services to be commissioned will secure delivery of the commitments and milestones in the Executive's Programme for Government (PFG). A number of milestones under these commitments are reflected in the specific standards and targets in the draft direction. For others, although specific targets are not included in the direction, the commissioning plan should detail how the relevant PFG commitments will be achieved.

The Committee will be aware that we are facing a very challenging time in health, given the financial regime within which we are operating. The 2014-15 year will be a very difficult one financially for the health service, and, in that context, it is even more important to have clarity as early as possible about what the health and social care sector is required to deliver. The Committee will note that, in a number of key areas, the commissioning plan direction seeks to maintain performance at the levels that should be achieved at the end of this financial year. However, where we believe that improvements in performance can be achieved, that is what will be required from the service.

On content, as was the case this year, the Minister has indicated that he wishes, as far as possible, to see a greater focus on outcomes and which places the emphasis on improvement in patient outcomes rather than on processes. We have tried to ensure that the text of the direction is as clear and as focused as possible, and we also want to ensure that the direction reflects appropriately secondary, primary and community sectors. Although, of course, the quality of treatment and care that is provided

in acute hospitals remains very important, as we focus more on care closer to the home, it is vital to ensure that the direction includes standards applied in the community.

We have also highlighted the vital role that health promotion and disease prevention can play in keeping people out of hospital to begin with. The proposed number of targets and standards in the draft direction has increased slightly from the current year. The draft has 33 standards and targets compared with 28 in the current year. These are shown against the Minister's priorities in the schedule to the direction. The increase reflects the inclusion of several additional targets that are really aimed at improving patient outcomes, taking account of patient experience and driving improvements in safety and quality of care, tackling important public health issues such as obesity and substance misuse, and delivering on the agreed transformation of health and social care services in line with Transforming Your Care.

Listening and responding to the needs and views of patients, clients and their families and carers has to be central to what we do, and one of the new targets in the draft requires the Health and Social Care Board and trusts to work with the Department in delivering a regional survey of inpatient and accident and emergency patient experience during 2014-15. That is one of the new targets, and that is the first step in a much bigger piece of work, which is aimed at gathering regionally consistent information on standards and outcomes of care that are important to patients to ensure that all patients have a positive experience of care in whatever setting that care is delivered.

The Minister also expects to see in 2014-15 clear evidence that the planned programme of transformation is being implemented, and the plan must provide details of how the services that are being commissioned will deliver transformation as well as the timelines and milestones for that implementation. As part of this, the draft direction includes specific targets relating to the way in which integrated care partnerships will operate and, in line with the 2014-15 PFG milestone, the shift in funding from hospital and institutional-based care into primary and social care services. To ensure that there is an emphasis on the role of home as the hub, the Minister has included an additional priority that is aimed at promoting social inclusion, support and independence for people living in the community, particularly older people and people and their families who are living with disabilities. We also have an indicator of performance direction that complements the commissioning plan direction, and that work is ongoing in the Department. The draft of that has not yet been completed.

In summary, the draft commissioning plan direction reflects the Minister's key priorities for 2014-15 and aims to ensure that services to be commissioned are as outcome-focused as possible and support the delivery of the planned programme of transformation as well as fully reflecting and underpinning financial context. We will consider any comments that the Committee wishes to raise on the draft, and, as I explained, the Minister plans to be able to finalise the direction for issue to the Health and Social Care Board and the Public Health Agency in early November. I know that that was a bit of a gallop through this, but I hope that it has been helpful in outlining where we are at this stage of the process. We are happy to take any questions. If there are any questions that we are not able to answer today, we will be happy to come back to you with the information.

The Chairperson: Thank you for that, Catherine. It is an important document for us to reflect on. I apologise because I may have to leave before the end of this session, but it will not be because of something that you said. I note that section 2 of the draft direction refers to the board producing a commissioning plan. It also states that the commissioning plan must contain an underpinning financial plan for the commissioning of services. I think that that is a change from last year, so the question is why is the Department now asking the board for a financial plan?

Ms Daly: We are saying that it is very important to have a fully integrated plan, and that is why it is very emphatic that this is not a commissioning plan on its own but that it needs to be underpinned by a financial plan. We need to drive that process forward and also include the transformation, so this has to be a fully integrated plan. The timescales around that are challenging, but our view is that this is what is necessary.

Ms Julie Thompson (Department of Health, Social Services and Public Safety): The commissioning plan has always had a financial section in it. I guess that, in section 2, we are being a bit more explicit about what is required. There have always been financial detail in the commissioning plan, and things such as a programme-of-care analysis were always asked for and included. We are simply being clearer in that section.

The Chairperson: So, the Health and Social Care Board always had to produce the financial information?

Ms Thompson: Absolutely.

The Chairperson: My other question is on section 2. On quite a number of occasions, the document refers to the agreed transformation of health and social care services and the transformation programme. Indeed, coming out of the allied health professional (AHP) event this morning were references to transforming care. There is no specific reference to Transforming Your Care in the commissioning plan. Is that a shift in thinking? Last year, Transforming Your Care was referenced clearly. There is no reference to the implementation plan either. Without that specific reference, what does the agreed transformation of health and social care mean?

Ms Daly: That is an interesting point and maybe something that we need to take on board, because when we refer to the transformation programme, we are talking about Transforming Your Care. Transformation needs to become fully embedded into the mainstream programmes. We have explicit targets in the schedule that are directly related to Transforming Your Care through the integrated care partnerships and the number of patients who should be identified and on the pathways in the areas identified by the integrated care partnerships. We also have a target in the draft about the shift of funding from the acute to the primary and community setting. The references to transformation are about Transforming Your Care, so it is absolutely not a move away from that; it is about embedding it. The strategic implementation plan has provided the overarching framework under which this commissioning plan and those transformation elements will be developed, so it is a move forward, and it is absolutely not a move away.

Also, on Transforming Your Care, I have identified two very specific targets. A number of targets in the direction are related to several proposals in 'Transforming Your Care'. For example, target 4, which is on tackling obesity, aligns with proposal 35 in 'Transforming Your Care', which is about:

> *"Preventative screening programmes fully in place to ensure the safest possible outcome to pregnancy."*

So, you can see the link between that and the obesity target. I will not go through them all, but we can pick out proposals 35, 27, 75, 86, 98 and 62 from 'Transforming Your Care' as they relate to other targets in the schedule that are not explicitly highlighted. Part of that is about mainstreaming that transformation and making it a part of everyday service delivery.

The Chairperson: With respect, the strategic implementation plan is not the legal basis of the document. I think that it is quite strange not to have the 'Transforming Your Care' document referenced. That is something that needs to be examined. Without that being very specific in the direction, what is the transformation of health and social care?

Ms Daly: I think that that is a very important point, and we will take it on board and look at it. The intention is not to move away from Transforming Your Care. However, if that is how it is perceived, we need to look at it.

The Chairperson: Thank you for that.

Members, unfortunately, I have to leave at this point.

The Committee Clerk: Are there any nominations for someone to take the Chair?

Mr Brady: I nominate Roy Beggs.

The Committee Clerk: Are there any other nominations? Are members content that Roy Beggs takes the Chair?

Members indicated assent.

(The Acting Chairperson [Mr Beggs] in the Chair)

Mr Brady: Thank you for your presentation. My first question is about the schedule. You said that, by April 2014, 50% of all eligible men and women between the ages of 60 and 74 will be contacted about bowel cancer screening. Is that a different 50% from last year, meaning that, by 2015, you will presumably have all the eligible people dealt with?

I have another question on the specific targets for the care of patients with breast cancer that you mentioned. Is there any reason for that? Is it because breast cancer is becoming more prevalent? Has it been singled out for more stringent attention?

Ms Daly: I will address the question about bowel screening. This is a progressive programme, and it is rolling forward. The age range under this target is now 60 to 74. It invites 50% of that age population to come for bowel cancer screening. In the next year, a further 50% will be invited, and it then becomes a rolling programme. So, it is progressing and will cover a bigger percentage of that age range.

Mr Brady: Will those people be those who were not necessarily contacted previously?

Ms Daly: That is right. Different people will be contacted; 50% in one year and 50% in the next. In addition, there will be a significant publicity campaign to ensure that people are aware of the availability of screening so that we can try to improve the uptake.

Mr Brady: What about breast cancer specifically?

Ms Daly: The overall target for breast cancer is 62 days. However, the 14-day breast cancer target is an important one. That was previously a target, and it had been included as an indicator of performance. In the current period and, I think, last year as well, there had been some deterioration against that performance, so the intention is to have that as an element of that target so that there is a very clear focus on ensuring that performance is maintained at those levels.

Mr Brady: So, early diagnosis and early treatment is the right thing.

Ms Daly: Absolutely.

Mr D McIlveen: Catherine, I would like a little more clarity on emergency readmissions. If I am reading the document correctly, I think that a 10% reduction was the target for last year, whereas the target for this year is 5%. Can you clarify why that is the case? Why has that target apparently been softened?

Ms Daly: That is an important target. The target has been set at a 5% reduction in the rate of emergency readmissions within 30 days. We are reviewing that to look at the basis of it. The target last year was —

Mr D McIlveen: It was 10%.

Ms Jennifer Mooney (Department of Health, Social Services and Public Safety): It was 10%. The subtle difference is that that was 10% in the number, as opposed to this year, for which a reduction in the rate has been proposed. The difference is that you are not taking a straight reduction in the number. It works out that that does not really represent a softening in the rate.

Ms Daly: The focus is on having valid information that is telling us about what is happening. As Jennifer said, there is an issue with that about whether we should look at numbers or at a rate. This document is a draft, so it may change, and we are engaged with colleagues in reviewing that issue to make sure that we have the most appropriate measure that gives us the information that we need.

Mr Gardiner: It is lovely to see you all here, and you are welcome again. Is the target for allied health professionals (AHPs) simply to reflect that no patient wants to wait longer than nine weeks for a referral? What is the position on self-referrals for physiotherapy? Has that been piloted yet?

Ms Daly: Sorry, Sam, will you repeat the last part of your question?

Mr Gardiner: What is the position on self-referrals for physiotherapy? Has that been piloted yet?

Ms Daly: I do not have the details on the self-referrals, so I will have to come back to you on that. The target of no patient waiting longer than nine weeks is in the current direction. It is very important to retain the view on that. There was significant improvement in performance, but that has deteriorated over recent months. The Health and Social Care Board is paying particular attention to that at the moment with the health and social care trusts. However, I would need to come back to you on the self-referrals.

Mr Gardiner: How much longer than nine weeks are patients now waiting? You said that that has deteriorated.

Ms Daly: The number has increased significantly. I think that, at the end of last month, the number was about 4,000 in total across Northern Ireland. That number had gone down significantly. Around the beginning of this financial year, the number was very low. It has increased. Various reasons have been identified for that; some of it is about difficulties in recruiting staff and renewing contracts. The Health and Social Care Board is looking at the issue because of that increase. Significant attention will be focused on that to bring it down.

Mr Gardiner: How soon will it be brought into line so that those people are not waiting for that length of time?

Ms Daly: The focus is that it needs to happen immediately. Given where the levels are, it will take time to bring them down. We are very clear with the board and the trusts that the nine-week target is the target. No patient should wait for longer than nine weeks. So, if anyone is waiting longer than nine weeks, that is not acceptable. It is about working with the board and the trusts to identify the reasons for that and to ensure that that is brought back on target.

Mr Gardiner: Will you let us know, please, when you are on target again? Six months, nine months or a year is a long wait. I want something to be brought into operation more speedily.

Ms Daly: We review that monthly with the board. The board reports on that monthly to its own board. It is meeting a number of trusts fortnightly to highlight the issue. Their attention is focused on the targets in which there is a drop in performance. As I said, there was such an improvement in the AHPs, but there has been deterioration. We in the Department are concerned about that, as is the board. The board is working with the trusts. I assure you that attention is being focused there to drive that back down, but I cannot give you a guarantee about when that will actually happen.

Mr Gardiner: As soon as possible.

Ms Daly: Absolutely.

Mr Dunne: I thank the panel very much for coming in. Following our debate in the Assembly in the past week or two, is an uplift planned in the bowel cancer screening programme?

Ms Daly: The intention is for that to be a rolling programme to hit the entire population of that age range. So, there would be 50% this year. The age range has increased this year compared with last year, and there will be a further 50% next year. It is a progressive programme that covers a wider percentage of the population.

Ms Mooney: It will be rolled out to the 60 to 74 age group from April 2014.

Mr Dunne: You have a target of 55% uptake. Is that high enough?

Ms Daly: The evidence suggests that that is what we should expect the uptake to be. The intention is to cover that full population, but there is always an issue of capacity. For example, it is simply not possible to cover 100% of that age range in one year. The target says that the uptake should be at least 55%.

Mr Dunne: Of those invited?

Ms Daly: Yes.

Mr Dunne: It does not sound a lot; it is only over half the people whom you ask.

Ms Daly: The Committee raised that issue with us previously.

Mr Dunne: I think we have raised it, yes.

Ms Daly: We looked at it to ensure that it is taken forward in the most effective way. That is being done in a manageable way so that we can get to the population as quickly as possible. The targets of 50% and 55% may seem small, but you have to take into account that it is a rolling programme and that the other 50% of that age range will be targeted in the next year. It is a continuous programme, so it is not as though somebody is invited to it once and drops out. It covers the entire population in that range.

Ms Mooney: The target of 55% is because you cannot compel people to partake in the screening; it is their decision.

Ms Daly: There is a significant publicity campaign to try to increase awareness of the opportunity for the bowel screening and of the implications of bowel cancer.

Mr Dunne: The Finance Minister announced some funding for dental treatment. What is that for?

Ms Thompson: That is a capital allocation for a range of equipment for dental premises. It is £2·5 million for dental premises and £2·5 million for GP premises for a range of equipment. The Finance Minister had drawn out the financial loan aspect of it. It was coming from that source of funding.

Mr Dunne: Is that available to private dentists?

Ms Thompson: It is there to provide a facility so that they can, effectively, get a loan to invest in their equipment. It is a means of allowing that to happen. So, we were very grateful for that.

Mr Dunne: That is good. Is that system new?

Ms Thompson: The financial loans transactions funding is a new funding stream from the Executive, yes.

Mr Dunne: Good. I am aware of the lobby for it from dentists. The dentists came to us rather than us going to the dentists, for a change.

We have been lobbied quite a bit about specialist drugs and drugs that the National Institute for Health and Care Excellence (NICE) approves. Will more funding be available for drugs for arthritis and so on?

Ms Thompson: We will work with the board on the entire funding for 2014-15 to identify what new drugs and technologies NICE is likely to approve for 2014-15, and we will ensure that we understand the financial implications of those as we move forward. So, we are continually putting more money into those elements to expand the amount of money that is spent on drugs. That has to be done within a funding envelope, as you will appreciate, and we have to ensure that we can manage within the overall resources that are available. So, we will look to see what is likely to come on stream and how much that will cost and ensure that we find a way to balance that in the books.

Mr Dunne: Where does mental health fit in? Commitment 22 in the Programme for Government states:

> *"Allocate an increasing percentage of the overall health budget to public health".*

The Programme for Government also aims to:

> *"Strengthen the cross-sectoral, cross-Departmental drive on improving health and mental wellbeing".*

Are additional resources going into that?

Ms Daly: It is not identified as an explicit target in the schedule to the commissioning plan, but we need to highlight that the schedule comprises a number of targets covering a small number of areas. The focus in the entirety is on the direction itself, which covers all health and social care services and mental health services. So, the intention is that those services are commissioned to meet the needs of the population in the most effective way possible with available resources. The fact that something does not have an explicit target in the schedule does not mean that it is not important. That is reflected in the text.

Ms Mooney: There are some specific mental health targets as well. That is target 28 in the schedule to the commissioning plan direction of the PFG. That concerns the extension and completion of the resettlement programme.

Ms Daly: That is a progression on the current target to ensure that that programme is completed by March 2015, as intended.

Ms Mooney: There are also access times in target 30 for mental health services, as well as patient discharges.

Mr Dunne: Are those issues that have been raised and that are seen as a priority in the schedule?

Ms Daly: Yes. There are areas that require a specific focus to ensure that performance is maintained at the level that is specified in the target. That does not necessarily mean that that level of service will be delivered, but it is absolutely what, in the Minister's view, should be delivered. It has a specific focus, as it is in the schedule.

Ms Brown: In the target on resources, the aim is to transfer £83 million from hospital- and institutional-based care into primary, community and social care services, excluding transitional funding, by March 2015. Will that be possible if the Department does not receive the required transitional funding from DFP over the next monitoring round?

Ms Daly: That is what we have to look at. The Transforming Your Care programme identified that £70 million would be required over the next three years to deliver the TYC proposals. At this stage, we have not secured the required in-year funding, and that will have to be considered in the context of the overall resource position and the implications for the implementation, and the pace of that implementation, of the programme.

Ms Thompson: We still have a further opportunity to go back through the January monitoring round for Transforming Your Care and the other bids that were not successful in October monitoring, and we propose to do so. So, that avenue is still open, but, as Catherine said, we need to reflect on what the options will be if we do not receive the funding.

Mr McKinney: Thank you. I am new to the Committee, so I am delighted to meet you.

I will return to the waiting lists that Mr Gardiner referred to. You said that 4,000 people had been waiting for longer than nine weeks and said that you were doing a lot about it. However, the issue is, of course, that that is the front-door experience for people; it is where they make contact. Is nine weeks sufficient, and is reducing the longer time from 18 weeks to 15 weeks doing anything for that experience? It is no major benefit for the patient to know that they are less likely to be waiting longer when so many people are waiting for treatment. We are getting this a lot in constituency offices, and there is a lot of dissatisfaction out there at the length of time that people have to wait for that contact and that treatment.

Ms Daly: You made a number of points there, and I cannot disagree with anything that you said about the whole patient experience and how the patient feels at that front-door experience. Going back a number of years, the targets across the elective care services were nine weeks, nine weeks and 13 weeks for inpatients, outpatients and day cases. We had to move back from that, which was regrettable, as that is where we have the maximum waiting times. The intention is that nobody should have to wait any length of time for a service, but the reality is that there are issues with funding and capacity. That is what we need to look at to see how we can ensure that services are delivered in the shortest time possible. We are saying that those are standards rather than targets at this point and that nobody should wait any longer than that. It would be so desirable for them to be seen much sooner than that. The Health and Social Care Board has a statutory responsibly for performance

management with the health and social care trusts. It is a significant focus of the board's to bring elective care waiting times down. There are capacity issues, and we bid in the October monitoring for £26 million for elective care waiting lists. We secured £14 million, so there is still a shortfall. That is an issue of demand and of services increasing. So, there is no one answer to this. Performance management is one element, but we also need to look at ways of managing demand to see whether there is an issue with that. We need to look at different ways of doing things, but it is a very complex process.

The Minister is extremely focused on the priority of the waiting list. He expressed his concern about that. He is extremely focused on the targets and on when there is deterioration. So, you are absolutely right that the patient experience is a major issue for the public at large. For the first time, the draft direction has patient experience targets, because that is another thing that the Minister wants to look at. He is hearing from patients, and he wants to know about their experiences of going through the service. However, this is a whole-systems approach, and that is the way that we need to address it. So, it is not that I can give you an answer and say, "Yes, this will change." However, your points are absolutely valid.

Mr McKinney: It is important to make them when we are experiencing that type of issue directly. I do not want to put words in your mouth, but given the gap between the nine weeks and your stated aim of trying to get people seen urgently and as soon as possible, is the situation out of control?

Ms Daly: No, we would not say that it is out of control. However, we would say that we need to look at the evidence and analyse it to say what the causes are and what can be done about it. As I said in response to a question about the AHP waiting list, a number of issues were identified there, and that is where the board is working with the trust to ask whether that is reasonable or avoidable and whether we can change it. Those are standards that need to be met, so it is an issue that is being addressed proactively.

Mr McKinney: The treatment times for people who are diagnosed with cancer are 31 days and 62 days. Is it acceptable for urgent cases to get their first definitive treatment within 62 days, given the angst that exists specifically about cancer, the threat of cancer and a cancer diagnosis? Could more be done to engage in treatment?

Ms Daly: In developing those targets, we engaged with clinicians across the Department and service to determine what was appropriate. The 62 days is for the first definitive treatment from referral. That takes account of that whole pathway and passage from GP referral until the treatment is given. That can take time.

There is a process for urgent, red-flag referrals, and those are prioritised. When a patient is referred, it will very much be a clinical issue, in that a consultant will determine what is appropriate. It is not the case that everyone who comes through will wait just to ensure that it is done within 62 days. A number of patients will be seen and will receive treatment much quicker than that, but in the context of the overall target, we aim to ensure that nobody waits longer than 62 days. However, a majority of people should be seen well within that time. There are then sub-targets of 14 days and 31 days.

Mr McKinney: The MRSA target was x%, but there is a comment in brackets after that in the schedule. Is there a reason for that?

Ms Daly: Yes, the reason for that is —

Mr McKinney: That is OK. You said that you are going to come forward in 2014. However, there is an x% for the unplanned admissions of adults with specified long-term conditions but no explanation and no time frame.

Ms Daly: The reason for the MRSA target is that we need to wait to have a full year's information to analyse that and set the target for the next year. So, we will have an x against that at this stage, but that will be quickly determined and put in place.

Ms Mooney: The unplanned admissions issue comes back to that question on emergency readmissions that we looked at earlier and whether you mention a reduction in the number or a reduction in the rate. Specifically, we are trying to find the best and most meaningful way to measure

unplanned admissions. That is another issue that we are looking at, and we hope to be able to finalise it very shortly.

The Acting Chairperson: Can I pick up on the issue of the patient experience? What are the targets for the waiting time to see a consultant, and, subsequent to that, waiting time to treatment? I understand that, in England, they measure simply the waiting time to treatment, because that is, ultimately, most important for the patient experience. Why do we use different mechanisms? Someone might have to wait an excessive time to see the consultant and then another excessive time to treatment, but that can be hidden in the whole process.

Ms Daly: Sorry, is this about cancer or just generally?

The Acting Chairperson: Just generally. What is the patient experience of waiting times? Why do we cut waiting time up into separate blocks, rather than adopt the method that is used elsewhere?

Ms Thompson: The English standard is 18 weeks from start to finish, if I recall correctly. There is a shorter period for England in getting from start to finish. We are not at that point, so we have broken it down deliberately to be able to focus on the different elements and to ensure that nothing goes adrift in those particular elements. Ultimately, we want to do what you describe, which is to bring it all together. We are just not at that point yet, and, therefore, we focus on the individual elements of the journey effectively all the way through to ensure that no patient will get lost as they move through the process.

The Acting Chairperson: I see that there is a new target on the inpatient experience. You indicated that you are going to do a survey of inpatients and A&E patients. You also indicated that this will inform a programme of work to secure long-term improvement. Can you give us a time frame for that survey and a time frame within which you hope to bring about conclusions or recommendations that may flow from that piece of work so that we are aware of what targets may come out of it?

Ms Daly: The intention is that that work would be taken forward over the next number of months so that we are in a position to put in place a target for 2015-16. We need to ensure that we have proper information to provide the baseline, and the intention is to develop a target or targets for the next commissioning plan process.

The Acting Chairperson: Can you clarify whether that is a further survey of patients? I was at an A&E unit some time ago, and a survey was being carried out on how out-of-hours doctors could treat some of those presenting at accident and emergency units. Is this a new survey on top of that survey?

Ms Thompson: Depending on the particular services that they are looking at, trusts will run individual surveys for their own purposes. We propose to get a consistent, across-the-region understanding of the position that we can use for benchmarking, best practice and moving ahead. It needs to be done carefully to ensure that we do not duplicate effort. Therefore, there has been a lot of work to ascertain what is going on locally and to make sure that it is consistent with what is done regionally. However, this is the first time that it will be done across the entire region on a consistent basis.

The Acting Chairperson: Thank you for attending the Committee and for taking questions.

Ms Daly: Thank you very much.