COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Commissioning Plan Direction 2011 and Draft Commissioning Plan 2011-12

20 July 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Commissioning Plan Direction 2011 and Draft Commissioning Plan 2011-12

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Members present for all or part of the proceedings:
Ms Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Michaela Boyle
Ms Paula Bradley
Mr Mark H Durkan
Mr Sam Gardiner
Mr Kieran McCarthy

Witnesses:

Mr Edwin Poots	)	Minister of Health, Social Services and Public Safety
Mr Fergal Bradley	)	Department of Health, Social Services and Public Safety
Dr Andrew McCormick	)	
Mr John Compton	)	Health and Social Care Board

The Chairperson:

I welcome the Minister, Andrew, John and Fergal. Minister, the Committee appreciates you and your senior officials coming to its meeting during the summer recess. The background to the issue is that the Committee saw the document on the draft commissioning plan that was leaked to the media at the end of June, and a number of questions occurred to us all. I knew that the board had a meeting that morning with the trade unions and that the trade unions were picketing outside while the board meeting was in progress. There was a great deal of consternation and concern

about what was in the draft commissioning plan and how it impacted on services for this year.

I understand, Minister, that you will make a short presentation and take questions from members. We welcome the fact that you have come in to do this. It is important that we are able to work with the Department to scrutinise areas that will affect not only our constituents but constituents right across the North.

The Minister of Health, Social Services and Public Safety (Mr Poots):
Thank you. We appreciate the Committee's gathering at this time. I know that the issue caused unease, and I trust that we will clarify the situation. The fault for the unease did not lie with us.

As usual, I am happy to engage with the Committee as and when required, including during the summer. I appreciate that there has been a lot of press speculation about the development of the Health and Social Care Board's draft commissioning plan for 2011-12, which has made members uneasy. I regard some of that speculation and the content of a number of articles as unhelpful. I hope that members will feel a bit more at ease at the conclusion of the meeting. With me today is the permanent secretary, Andrew McCormick, and the chief executive of the Health and Social Care Board (HSCB), John Compton.

As I outlined previously, we face challenging times, not just in the health and social care sector, but with the economy in general. However, the Executive have provided a degree of protection for health across the Northern Ireland Budget over the 2010 period, with the settlement increasing spending by 8%, from £4·3 billion in 2011-12 to £4·6 billion in 2014. That may sound generous, particularly given the block grant. However, given the increasing demands that we face, it is a very difficult settlement indeed. The rising level of need for health and social care services is the main backdrop to the planning that we must undertake and the decisions that we will have to make over the coming years. Here, as in all parts of the Western World, the combination of an ageing population, advances in medicine and rising public expectations mean that it is increasingly difficult to provide sufficient resources to deliver on the NHS model of universal care free at the point of delivery and on the promises that the best available cost-effective treatments or services will be provided. England faces the unprecedented challenge of delivering cost improvements of £20 billion, or 4% a year, for four years, and the position here is similar.

If we assume that services will be delivered in the same manner as currently, we face an estimated shortfall against assessed needs of approximately £300 million this year, with a potential rise to £800 million in 2014-15. That means that we must make the best possible use of every penny that my Department has been allocated. It also means that we must use resources in the right way and spend our money on the right things. It does not necessarily mean that that has to be done at the cost of reducing services: we can deliver equivalent services, but in a different way. To ensure that we can live within our means, the key priorities of improving patient and client outcomes and improving quality and access, while striving to improve productivity, efficiency and effectiveness, must be at the heart of our plans and decisions.

Let me put the draft commissioning plan for 2011-12 into context: the Health and Social Care (Reform) Act (Northern Ireland) 2009 is the legislative framework within which all health and social care structures operate. It also sets out the high-level functions of the various health and social care bodies. Acting under my direction, the Department of Health, Social Services and Public Safety has a general duty to promote an integrated system of health and social care. It also has specific responsibilities that include determining and, when appropriate, varying priorities and objectives for the provision of health and social care in Northern Ireland.

Section 8(3) of the reform Act requires the Health and Social Care Board to prepare and publish a commissioning plan for each financial year after consultation with, and the approval of, the Public Health Agency (PHA). The Department sets out the Minister’s instructions to the commissioners in an annual commissioning plan direction. As members will be aware, commissioning is a process that looks at the needs of the population and plans and secures health and social care services to respond to that need within given financial parameters, with the objective of improving and protecting the health and social well-being of the population and reducing differences in the access to quality healthcare and quality of life.

The commissioning plan direction specifies the required form and content of any commissioning plan in terms of the services to be commissioned and the resources to be deployed. The commissioning plan should demonstrate how the totality of revenue resources has been committed to individual organisations and disaggregated by local commissioning groups (LCGs). Any resulting commissioning plan is subject to ministerial approval prior to implementation.

I agreed to the issuing of the commissioning plan direction for 2011. It sets initial priorities for 2011-12 and was issued to allow the board to meet its statutory obligation to develop a draft commissioning plan that sets out the details of the health and social care services that it proposes to commission for 2011-12. The direction was drawn up on the understanding that that transitional measure was necessary to enable services to continue to be commissioned in line with statutory requirements.

The draft commissioning plan for 2011-12, submitted to the Department on 4 July, is being reviewed by officials and will require my approval prior to implementation. The law as approved by the previous Assembly prevents the HSCB and the PHA from publishing the commissioning plan before it has been approved by the boards of those two organisations. The plan had been to publish the draft commissioning plan only a day after it appeared in the press, and, on that basis, it would have remained subject to my approval. So whoever chose to leak the commissioning plan and had it published in the press before I, or indeed the Committee, had a chance to see it was not acting in the interest of the Health Service. He or she allowed the press to lift elements of the plan and put them into the public domain. It would have been much better had I received it in the first instance, prior to its entering the press.

Mr Gardiner:

Minister, may I ask a question? Have you been able to trace the person or persons who leaked that information?

Mr Poots:

Not as far as I am aware.

Mr Gardiner:

Was it someone in your Department?

Mr Poots:

Most likely, it was someone in the HSCB or the PHA. However, that is where we are. The press became aware of the material and questioned the Committee Chair about it, but I had not been made aware of it at that point. I could not have been aware of the material, because, in fact, the PHA and HSCB had to meet that morning in order to be able to put it to me the following day.

Mr Gardiner:

I am trying to take the blame from you. It was —

Mr Poots:

The day before that, and before the meeting took place, the material was leaked to the press. However, that is where we are. We get on with life. These things happen.

The draft commissioning plan for 2011-12 is HSCB's response to the commissioning plan direction issued to it. It is not the agreed way forward or the direction of travel for health and social care. It may be for elements of it, or it may be for all of it. It would be premature for me to try to give a full response to the draft commissioning plan as it is still being considered, but I want to clarify two main steps.

There is a pressing need for some service changes in the short to medium term, and I will engage with the Committee on those changes at every appropriate stage when that is feasible. Some changes will flow from the proposals in the 2011-12 commissioning plan, though I have not reached any final conclusions on the majority of issues that it contains, as we received it only recently.

For the medium to long term, decisions on reconfiguring health and social care will be based on the outcome of the health and social care review, which I am initiating. A great deal has been made of the consultation on the proposed changes. I want to be clear that consultations will take place on specific short-term proposals, but, more importantly, I intend that the review team will engage fully with stakeholders, including the Committee, in developing its proposals.

The recent press coverage, which has raised so many concerns, was premature. The media headlines are not an accurate reflection of the current situation. I cannot blame the press for running with what was good copy for them, but those who prompted the coverage in the first place need to think carefully about their motivations and the best long-term interests of our people.

We face difficult challenges, and we need a mature, evidence-based debate on how we move forward. Those who have a view on how we can face all of those challenges have the opportunity to make their case to the health and social care review and must be prepared to compete and

debate with those who have alternative viewpoints on what we should do. Using the media to whip up false fears is not the way to proceed and will lead to critical decisions being deferred or not being made at all, which could lead to potentially catastrophic consequences for our ability to meet the health and social care needs of our people not that far down the road. Members should note that it is my intention to make the necessary tough decisions as and when they have been debated and thought through fully.

There are clearly identifiable ways to improve both the productivity and efficiency of health and social care. Being made more efficient, however, does not only have to be about working harder and harder with less. Salami-slicing is not the way forward. Instead, we have to challenge the status quo, stop doing what does not work and acknowledge that some of today's services and their current design are no longer fit for purpose. I also need to emphasise again that we need proposals that reduce net cash outgoings. Improvements in productivity are important but will not suffice to resolve the problem.

We need to encourage greater personal responsibility among members of the public for their own health and well-being and to manage demand and expectations by ensuring that their use of the health and social care services is appropriate. Accident and emergency departments in our hospitals, for example, should be dealing with accidents and emergencies; they should not be used as a surrogate for services already provided by GP surgeries and other primary care providers.

We need to limit unnecessary hospital care. Too much work is carried out in hospital that can be carried out at a primary care level. That means ensuring provision of good intermediate care, rehabilitation and community support. We also need to promote the use of multidisciplinary community teams for chronic conditions, such as heart failure and chest disease. Through managing such long-term conditions in the primary and community sector, we will provide the information, support and early interventions that enable people to manage their conditions better and maintain their independence, and we will reduce avoidable hospital admissions. People given that type of support are more likely to experience better health and well-being, to use their medicines effectively, to remain at home and to have greater confidence. They also have a sense of control and better mental health.

The move to more community-based care requires a range of services focused on, for

example, early diagnosis and intervention, bolstering multidisciplinary community teams, rehabilitation and good intermediate care services, self-care, education for self-management and support for carers.

As previously outlined, I will not make any long-term decisions or set any longer-term priorities and objectives for health and social care in Northern Ireland without the full range of information being available to me. The draft commissioning plan for 2011-12 is but one element of that and does not commit anybody to anything at this stage.

When I first met members of the Committee on 8 June, I said that I wanted to keep you all apprised and, as appropriate, to involve you. Everyone makes use of the health and social care service at different times in their lives, from highly complex and sophisticated surgery to basic social care in people's homes. It is important that, in these challenging times, when important and difficult decisions have to be made, we all pull together for the good of healthcare for the people of Northern Ireland. I stress again that there will be full and open engagement with all stakeholders, including the Committee, on the development of proposals by the health and social care review, and proposals will properly be consulted on. Nothing has been agreed or ruled out at this stage, nor should it be.

That brings me to the conclusion of my opening remarks. With your permission, I will comment briefly on the issue of junior doctors and apprise you of that situation.

The Chairperson:

I appreciate your offering to do that, Minister, and we look forward to hearing that. However, given your quite lengthy presentation, it may now be more helpful to go to questions on the issues that you raised.

Mr Poots:

OK. I am in your hands.

The Chairperson:

You said that there would be full consultation on the health and social care review with stakeholders. At the risk of sounding a wee bit stupid, Minister, I will say that the paper that we received from the Department on Monday was, at times, quite confusing because it dipped in and

out of the commissioning plan and the commissioning review. You said that there would be full consultation on the review, which we certainly welcome. However, I am keen to drill down into some of the issues of the consultation on the commissioning process.

UNISON emerged from the board meeting on 30 June 2011 to state that it welcomed the fact that it was made clear at that meeting that it was a draft commissioning plan and that there would be consultation. However, I heard differing messages as you spoke. I suppose that, again, I am a wee bit confused, because the draft plan is meant to reflect the priorities set out by you in the commissioning plan direction'. However, the direction was dated 24 June and the draft commissioning plan was dated 23 June, which suggests that the draft plan was produced before the direction was received instead of the other way round. Will you talk us through the chronology? Also, will you consult on the draft commissioning plan? If so, with whom will you consult and in what timescale? It would be interesting to hear what level of consultation there will be. Furthermore, you got it back on 4 July. Today is 20 July: in those 16 days, have you garnered any initial views to share with the Committee?

Mr Poots:
There are two different scenarios here. There is the overall review of the service provided, on which we will fully consult before decisions are made on that report. That is a long term —

The Chairperson:
On the review, yes.

Mr Poots:
That is separate.

As regards the plan produced annually by the HSCB, the board is required to consult with the PHA and put it to the Minister, who then considers and approves the draft. That is not something that would normally be consulted on.

With the Committee's permission, I will defer to Andrew on the chronology.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):
We work very closely with the board, so there was a lot of engagement throughout June on the

work that we were doing with the Minister on the development of the commissioning plan direction. That was not finalised and signed until 24 June, but the board was well aware of its main components, on which it had been working.

In an ideal world, we would have been doing the commissioning plan direction and the commissioning plan well before the start of the financial year. We were concerned that not completing a process before the end of June would have left the system in a vacuum. It would have been totally unacceptable to have left the system without a clear statement of direction and a clear basis for working. That was subject to further approvals and lots of debate, but the statement of direction allowed the whole health and social care system to be aware of that. That is why we worked towards the deadline of the HSCB board meeting on 30 June. So during that month, we were explaining to the board what was emerging. Changes were being made right up to 24 June, but we signed and sealed the direction on the Friday. The draft commissioning plan then went to the board meeting. The cover page is dated 23 June, but it probably did not issue to members of the HSCB board and the PHA until Monday 27 June.

In that sense, the sequence was orderly. We worked very closely together, so there were no great surprises. Nevertheless, a clear formality was that the first move was for the Department, under the Minister's authority, to issue the commissioning direction on that Friday afternoon. The papers were subsequently issued to the board members on Monday 27 June for consideration at the board meeting on 30 June.

The Chairperson:

It is interesting to hear that the plan, once completed, goes to the Minister for approval, so there is no further consultation. UNISON seems to have picked that up wrongly; it felt that further consultation would follow the meeting on 30 June.

Minister, the Committee welcomed your making comments in the public domain on preventative medicine and other ways to keep people out of hospital. However, the draft commissioning plan does not seem to give much of a nod to targets in preventative areas. Prevention is the right way to go, but the plan does not seem to contain much direction on that. It does not seem to be your plan as much as — dare I say it — John Compton's.

Mr Poots:

I assume that part of the issue is that the draft plan is for 2011-12. Many of my thought processes are concentrated on how to resolve issues over a longer period. I will allow the plan's author to respond.

Mr John Compton (Health and Social Care Board):

The process followed for the commissioning plan this year is exactly the process that was followed last year. Nothing different has occurred. The well-established process is that there is close liaison with the Department on ministerial direction, and we liaise closely with our partner organisation, the PHA, on the production of a plan. The plan is shaped so as to recognise clearly the authority of the Minister.

At the board meeting, we were clear that our normal format was to circulate the plan, which includes giving it to, for example, UNISON. We have done so and agreed to meet on, I think, 24 August. That is UNISON's suggested date; we would have preferred to meet slightly sooner, but I guess that summer and holidays got in the way. We will talk to UNISON to ensure that it is clear about the implications of the plan. We gave that assurance at the board meeting, and we will discharge that obligation fully.

The plan is available for the Minister and colleagues to comment on. We will, of course, have to take account of any deficiencies or perceived deficiencies. If they exist, the plan would have to be altered in whatever way was deemed appropriate.

All I can say about prevention is that colleagues at the PHA were extensively involved in the sections of the plan that cover that area. There was no editing on the part of the board to restrict what was included in the plan. I am not able to speak fully for the PHA, but my understanding is that it was entirely content that the plan recognised the importance of prevention and the associated issues. The plan specifies some of the areas in which there are inequalities, the product of inequalities and the difficulties with inequalities in lifestyle and health expectations for disadvantaged communities. If that is not presented strongly or thoroughly enough, that will be part and parcel of our iteration with the Minister and Department.

The other trigger of the plan is that it goes to the trusts and primary care providers to enable them to outline how they will respond to the direction of travel that it identifies. Processes are

running in parallel, but no one is taking any decisions because, ultimately, as the Minister pointed out, the overall authority for, and decision-making on, any issue in the commissioning plan rest with him. That is entirely as it was last year, when the commissioning plan went through exactly the same process. Indeed, I believe that, at a slightly later point last year, I came to the Committee last year to discuss and run through it. After that, we get the authorisation.

Consultation beyond that depends on what is incorporated in the draft commissioning plan. Any agreement on the full-year provision of new services that started last year does not require consultation, but there will be consultation on any material change that marks a reduction in service.

If the change concerns the location or centre in which services are provided, there will also be consultation on that. Those consultations will be run by the the board in situations in which it takes the lead, or, if a consultation is on a service continuing but moving from one location to another, it will be jointly run by the board and the trust involved ahead of the change being made. There is a clear commitment to consultation.

It is also worth noting that the local commissioning groups and the ongoing consultative work with a range of organisations are strong elements in the production of the plan. Therefore, the plan is not produced in a darkened room but is a point-in-time expression of work taking place throughout any given year. There will be much contact with voluntary organisations, interested groups and local communities through the local commissioning groups, and needs will be expressed in that way. Clearly, we can always do better, and we always receive requests for further consultation. However, we did better with our consultations this year than last year, and we will do better again next year.

The form of the consultation that takes place after a decision is made will depend on what that decision is. If that decision means a change of a location or something of that nature, the normal consultative processes will apply.

The Chairperson:
At this stage, do you envisage changes to the location of services or anything like that being included in the commissioning plan, or is it more likely that those would be kept for the review?

Mr Compton:

As I understand it, the commissioning plan is a direction of travel for this year, and we are pre-committed to a pattern of movement in 2011-12. The review will be much more concerned with what we will do in 2012-12, 2013-14 and 2014-15. The two are not disconnected. It would be remarkable if they were totally different, but they are separate processes.

We are finalising the position, and the Minister is keen for me to give him a commentary on the review towards the end of November. He is keen that we begin to make some form of strategic statement about the direction of travel into the future, and rightly so given the complexity of the times. Some signals as to the direction of travel are clearly containable in the commissioning plan.

The Chairperson:

John, the unions were very angry before the meeting on 30 June.

Mr Compton:

Yes.

The Chairperson:

You outlined that the process this year is the same as last year.

Mr Compton:

It is exactly the same.

The Chairperson:

Is the plan not structured differently this year? Are there not commissioning intentions rather than proposals for delivering the Minister's priorities in this direction? It strikes me as strange that there was so much of a furore about this year but no such furore last year. The timescales seem similar, and we are only a month out of the process from last year. The Minister has set out his direction, which is part of the plan, and I welcome the fact that you are meeting the unions. However, I do not feel that we have received enough information on this year's commissioning plan to enable us properly to scrutinise it. The Committee needs to know whether the plan contains, for example, the 2,000 posts that have not been filled through natural wastage in the past 12 months. The unions highlighted that, and we have spoken about it before. I cannot help

but wonder how, when people are moved out of a job and not replaced, which is one of the Minister's priorities, we will cope without having time for planning. For example, Pauline Haslett, who won the Nurse of the Year Award this year, is the live donor transplant co-ordinator for the entire region. She may decide that she does not want to stay in her highly specialised job, yet your target for live organ donors this year is 50, and Pauline is critical to that being achieved. So suppressing posts is not the proper way to plan for delivering healthcare. If 100 midwives retire this year, do we have enough midwives to provide a safe maternity service? Those are the kinds of questions that are put to members of the Committee.

Mr Poots:

Again, it is non-essential jobs that we are looking at not being replaced. The essential jobs are still being replaced. That recruitment is ongoing. A decision is taken on what is essential and what is non-essential. If the decision is taken that the vacated post is non-essential, it will not be replaced. I have decided that those posts should not be filled, and they no longer exist in the service. The unions are correct: those jobs have been done away with now. However, if someone resigns or retires from an essential post — a consultant goes or Pauline Haslett or whoever resigns — the post will be advertised and refilled.

The Chairperson:

Minister, you welcomed the fact that people who work in the Health Service carry out very important jobs. Although we are trying to fight against MRSA and clostridium difficile, posts that are part of the cleaning contract might not be classed as essential, but they are a very important part of delivering a quality Health Service.

Mr Compton:

It is important to connect two years. In 2010-11, to achieve the financial balance published in the commissioning plan for that year, we included a control mechanism to allow us to break even. That control mechanism, which was published, approved and agreed, was £40 million of workforce control to target non-essential jobs, to maintain better control over locums and to maintain better control over agency and overtime spend. It equates to the equivalent of 2,000 jobs. You might say to me, "Give me 2,000 names", but it does not work like that. It is about a £40 million control on the workforce. Given that we were criticised last time for not being specific about the implications for the workforce, we decided to remind everyone that the break-even position for 2010-11 included a £40 million workforce control figure equivalent to 2,000

jobs. That was delivered, is now a permanent feature for 2011-12 and beyond and has led to a significant reduction in jobs deemed non-essential.

The second point about non-essential jobs is that, as you improve productivity and the way in which you do things, that is partly about a reduction of your workforce. So if you have a team of 10 people and you organise it to work in the same way and with the same volume of work with eight people, you will reduce that team by two. A lot of that work happened throughout 2010-11, and it led to the position where the £40 million was substantially achieved. From memory, I think that about £36 million was out of the system at the end of the year. That is the position.

The Chairperson:
Is that year-on-year?

Mr Compton:
Yes. To avoid the criticism that we received last year for not being specific enough about the implications for the workforce, we stated our position up front. We said, "You will remember what last year's plan stated, this is what we delivered and this is what it equates to." However, it is not applied in a haphazard manner so that if a job falls out of the system, that job is gone. Every job is looked at in the context of the way in which services are organised. Productivity plays a part, and managing overtime and locum and agency budgets is important, as is managing how jobs are organised. I am not aware of red pen being put through any job that has been seen as absolutely central to the running of the service.

The Chairperson:
OK. I will invite members to ask questions. If we could keep to the draft commissioning plan for this year, that would be very helpful.

Mr Wells:
Minister, I am still intrigued about the issue of consultation. You said that you will consider the draft commissioning plan and that you will make the final decision on that. That is fine. However, you have also said that you will meet the unions in August to discuss the plan, not the review. Am I right?

Mr Compton:

Correct.

Mr Wells:

This morning, I had a meeting with a group that had read the draft but felt that dementia had not been mentioned and that there was totally inadequate provision for dementia sufferers. How would such groups have input into the final plan? Will there be a formal process whereby they can write in or meet staff, or will they be told that, apart from the meeting with the union, there is no formal process for consultation?

Mr Poots:

There is no formal process. However, given the devolved system of government that we have, I constantly receive letters from MLAs on behalf of groups and individuals, and I receive letters directly from both individuals and groups. All of those will be considered, responded to and dealt with. I will always give cognisance to the views of the Committee and its members on healthcare. There is considerable opportunity for people to correspond with me and allow me to take their views into consideration.

John's task was to produce a report for me; mine is to decide how we carry things through. An awful lot of this is repetitive. The vast majority of this year's commissioning report will be similar to what was in last year's and what will be in next year's report. That is the nature of it. If radical changes are to be made as a result, we will have to consult publicly on them. If large chunks of some hospitals are to be closed, that will be a matter for public consultation, and we cannot proceed without doing that. So there are elements of it that we will publicly consult on in due course if we decide to go down particular routes. However, the report as a whole is not something that is up for public consultation in the same way as, for example, the Budget would be.

Mr Compton:

For example, the commissioning plan specifies straightforwardly that we will spend about £20 million on demographic pressures. Dementia is a key issue in demographic pressures. It is not articulated well enough in regard to those sorts of issues, and, through the various existing channels that we have, people say to us, "Can you make it clearer that you are going to do that?" Of course, we will make it clearer. But the Minister is right: the normal process for this is not a

formal consultation. Consultation would flow if, in that particular example, we were going to curtail, remove or do something with dementia services. Clearly, we would consult on that. We do not propose to do that in this case. That is where it is.

It is important that people read the plan not as a one-off piece of work but as part of a running plan at a fixed point in time. It is correct to say that there will be a degree of continuity in last year's plan, this year's plan and, depending on what the review says, next year's plan. The whole health and social care system is not reviewed and changed annually. The plan is a statement of direction, decision and proposal, and it is a recommendation to the Minister for his final decision on how the health and social care system and services should be available.

I am more than happy to come and give a detailed presentation to the Committee on the plan. We did that as a part of last year's routine.

Mr Wells:

I raised this issue last year, and I think that it is even more important for the year 2011-12. We are now at 20 July, which is almost in the middle of the planning year. Can we get ourselves into a position in future years of developing a plan before the boat sails? It strikes me that it is difficult to implement some of the plans within the year, given that, by the time it is all agreed, half the year is gone.

Mr Poots:

I totally agree that the timing is unsatisfactory. For our longer-term priorities document and the commissioning plan direction for 2012-13, we intend to do that by January 2012. That should enable HSCB to submit a draft commissioning plan by the end of February 2012, so that due consideration can be given by the Department to the draft plan and the commissioning plan process for 2012-13. This year, the election was an issue, no direction was given by the previous Minister, and so forth. We are where we are this year. That was outside of our control, but it will not happen again next year. In particular, next year's timing will fall in with receiving the PEDU report and the health and social care review. In any event, I will seek to produce a longer-term plan.

Mr Wells:

There are three issues running in tandem: the review, which John is looking after; the

commissioning plan; and the fact that you are still trying to find money to balance the budgets for the present financial year. I hear that you are still trying to find between £75 million and £85 million in the system. The difficulty is that I presume that that work is ongoing. When you make those decisions, they will clearly have an impact on the commissioning plan. Can you formally agree a commissioning plan before you know exactly what you have to find in the budget?

Mr Poots:
As the accounting officer, Andrew's role is to identify how we will find the £75 million to £85 million.

Dr McCormick:
We are working hard on that, as the Committee is aware from our previous discussions in June. The letter that I sent to John at the time that the commissioning plan direction was issued said that we would need to look again at this in September. PEDU will report in September, and, at that stage, we will have a view on what further interventions in our internal activities are needed to balance the books. At that stage, we will take a view on what else can be done, what lessons we can learn from McKinsey's work and on the other things that PEDU asks us to do. PEDU will ask whether there are other means of delivering efficiency and productivity that can release cash and whether any changes being applied in other jurisdictions are not being applied here. We must to go through that entire process as well as determining whether there is any change in the total budgetary position.

At the Minister's previous appearance at the Committee, he referred to the need to seek some additional resources. We need to find the right balance and the best possible outcome. We will issue a revised commissioning plan direction for 2011-12 based on the outcome of that work, which will mean some revision to the draft commissioning plan. By definition, those issues cannot be resolved and decided until the financial position is resolved.

Further work will be carried out in September, and that will blend into the work of the review. We will look forward into an 18-month horizon to try to make sense of that and get a coherent plan for the rest of 2011-12. We will look forward into 2012-13 to try to get a stable, sustainable and deliverable plan. That is part what of what we aim to achieve. It is a matter of balancing the need to secure high performance in the service, which means delivering the key targets for standards of service. To ensure that we always hold quality of service as the pre-eminent

consideration, an extensive list is attached to the direction that the Minister approved. Every trust and every provider should deliver safety and quality as the first and overarching requirements, and all should balance their books. As the Minister said, we have an obligation, as a group of accounting officers — I am not entirely alone — to secure financial balance.

The Chairperson:

Jim asked about the consultation. Minister, can I take it that you have an open-door policy for anyone who wants to write to you? If there is no formal consultation process, people need to be aware that they can make their points.

Mr Poots:

Given the time frame, it will be difficult for the Committee to give its view as one. If individual members wish to write to me, or if the Committee wishes to meet and come to a composite view, that is fine by me. I will take views from whichever source.

The Chairperson:

If you are meeting the trade union on 26 August —

Mr Compton:

From memory, it is 24 August.

The Chairperson:

The Committee will reconvene on 7 September, so perhaps we should come back to that then. We would like to hear your thoughts, and if you are still consulting over the summer, the Committee might take your mind on the position in September. The draft commissioning plan does not contain all of the priorities and targets listed in the direction. Missing are, for example, targets on waiting lists for arthritis, multiple sclerosis and wet age-related macular degeneration (AMD); increasing the level of generic prescribing to 66%; reducing the number of unplanned hospital admissions to 10%, and terms and conditions for subcontracting. The draft commissioning plan does not seem to have all the things that were in your direction. Could we get a commitment on the date for approval of the plan?

Mr Poots:

OK; that is fair enough. We will probably wait for the completion of the PEDU review before we

give the final sign-off, but other issues in the plan will be signed off in the meantime. It is essential that that happens. We will consult the Committee and take its view before we finally sign off on the more controversial issues, and we will hear what PEDU has to say about where it sees that savings can be made.

Mr Durkan:
Thank you, Chairperson. You asked some of the questions that I wanted to ask. I welcome the Minister and thank him for coming. I declare an interest as a former member of a local commissioning group.

Minister, you said that the draft commissioning plan was a response to your commissioning plan direction. Unfortunately, it is not just the dates that do not correspond to that. The Chairperson touched on some issues, and I accept that your longer-term priorities would not necessarily be included in this year’s commissioning plan, let alone your commissioning plan direction. However, as the draft commissioning plan is, effectively, out for consultation with you and is awaiting your approval, I am curious as to how you could approve it without including what you have put in your commissioning plan direction. Should you try to fit those into the commissioning plan and at what expense? I could not say that I disagree with any of the targets that you identified in your plan, but I want to know what the implications could be if they were shoehorned in to allow you to put your fingerprints on the plan, as you would be entitled and right to do.

The other issue is the non-essential posts that have not been filled. The Chairperson touched on how a non-essential post is identified as such. Does that differ from what is in the commissioning plan for that particular year? I imagine that it might throw up equality issues.

You also mentioned A&E units. That issue is, has been and will continue to be a huge headline grabber. I would have liked to see more discussion in the plan about allocating resources towards keeping people out of A&E units, which are the most expensive parts of the Health Service. I know that your longer-term priorities, such as health promotion, will keep people out of those units, but I would welcome the allocation of more resources towards primary care and to GPs to allow them to carry out a greater number of minor procedures in their surgeries in the community. That would keep people away from hospitals.

Mr Poots:

Our initial response to the HSCB should be ready by the end of July — hopefully next week. That will highlight the areas of concern to us, including any gaps that we might identify. We have been benchmarking the plan against the direction in which we wish to travel. We will communicate the results of that as part of our initial response to the plan.

A lot of the stuff that you are referring to, Mark, relates to our longer-term notions and ideas. We are committed, even at this stage, before the health and social care review takes place, to move towards more primary care being given. If we were not moving in that direction, we would be moving in the opposite direction to everybody else in Europe. Hospital care is an expensive form of care, and, very often, people are being offered the opportunity to go into a situation in which there is the potential for cross-contamination, and so forth. Outcomes are much better when there is the capacity to deal with people in the primary care sector.

I was with James Reilly earlier, who said that a primary care clinic has opened and deals with 1,400 people who have diabetes. That unit, which deals with diabetics at primary care sector level, has not lost a limb since the process kicked off. People can go to their GP, who has responsibility in the primary care clinic, and be referred to a physiotherapist or a dietician all under the one roof. That is better than going to a GP and being referred for a hospital appointment to see those specialists. All of that should be available on site.

That is the mode of direction, but that will be dealt with in the health and social care review. Future commissioning plans will be better placed than this one to respond to that. We have to deal with the here and now and what we do this year. A lot of the big decisions cannot be made in that time frame, and that is why the draft commissioning plan is as it is.

Mr Durkan:

Thank you, Minister. I realise that some issues are longer term, but the shorter term issues that the Chair touched on, such as the 66% generic prescribing target, therapies for MS and arthritis, and so on, were included in your direction but are not in the draft plan. Should you endeavour to squeeze those into the plan? Would that push something else out of the draft plan? If so, how would that decision be arrived at?

Mr Poots:

Perhaps John will respond to that and talk about where we have set our priorities and how he has sought to include them without their being to the detriment of an existing service. His main task is trying to meet growing need within a constrained budget, which, as things stand, leaves a deficit.

Mr Compton:

Much of what you are saying implies that the document may not be clear enough for you, and I accept that. However, if you look at page 83 of the draft plan, for example, you will see the standard target times of nine weeks and 13 weeks that people expect.

You mentioned some pharmacy issues. On the financial side, we are quite clear about making £30 million savings this year through better handling of the pharmacy budget. That takes us to the introduction of the English formulary and the enhancement of generics to at least 66%. In fact, we are just about at 66% now and want to push beyond that.

The difficulty with these sorts of documents is that we are always breaking into a running programme of activity and, therefore, it is extremely difficult to encapsulate every detail. Sometimes, we are criticised for producing documents that are so verbose, thick and deep that people cannot find their way through them. We have tried to produce this, maybe not correctly, in a way that is, at least, readable, clear about the direction of travel and clear about the key issues. However, much of what you have said is, if not explicitly clear in the plan, underpinned in the plan and by the way in which it is presented. If, after the Minister has studied the plan, we are required to re-present the plan to articulate that and make it more straightforward, we will do so. However, those issues are clearly at the front and centre of what we are doing.

The Chairperson:

We welcome the fact that you are trying not to be verbose, but we would like the Minister's thoughts to be included. He is the one person whom we would want to say that we were able —

Mr Compton:

We hope that we have included most of the Minister's thoughts, but, if we have not, we are very happy to change the plan, which, ultimately, is the Minister's. We produce it, but it becomes the Minister's plan.

Mr Poots:

I would hope, where possible, to reflect the Assembly's thoughts, because the Assembly is representative of the people. I have been put here by the Assembly and, ultimately, the people. We need to respond to the public as best we can. You cannot always respond to the public, because sometimes their expectations are not deliverable and the less that we need to try to engage in that sense.

The Chairperson:

The point that we are making is that, although we welcome the Minister's priorities, they do not seem to be writ large in the plan. That seems a wee bit strange.

Mr Compton:

That is fine.

The Chairperson:

The Minister is right to point out that he is accountable to the people —

Mr Compton:

I accept that.

The Chairperson:

Mark was trying to tease out information on the non-essential posts. Maybe you could give us an example of a non-essential post.

Mr Compton:

For example, when one of the organisations changed its telephony services to make them more automated and centralised, fewer people were needed to work in telephony. Therefore, creating the opportunity for change allowed the workforce to be reduced. In that regard, those posts became non-essential. The technology for handling how to enter telephony into the system changed, so they moved from the old telephony system to using modern telephony technology.

The Chairperson:

That is a fairly obvious one, John, but you did not get 2,000 of those.

Mr Compton:

No. As I said, we put the figure of 2,000 in because we received a lot of criticism for not saying what workforce control meant and what it was analogous to. It is analogous to 2,000 posts. As I said, it comes from a mixture of looking at the telephony-type scenario, controlling overtime, controlling bank and agency nursing and putting those sorts of limits on it. All that combined gets us to £40 million.

People then asked what that means on the ground. As I said, it is equivalent to 2,000 posts in the middle of the system. We have had workforce control. We have sought, when commissioning the system, to ask our providing organisations to do what they do more efficiently. So if you move elements of inpatient surgery to day surgery and the percentages are there, you change the configuration of your beds. If you move the length of stay by half a day, you change the total number of beds that you need inside the system, and you do not do that simply on the basis of finance; you do it on the basis of what is more efficient and what is better for patients. So it is not about trying to do cheap and nasty enterprises; it is about trying to do the correct thing, which then allows you to control and look at the workforce in a different way. All those things were applied throughout the system last year.

Mr Poots:

All of them at grade 3 in the Department.

The Chairperson:

Apart from agency workers, and so on, do any of the non-essential posts involve medical jobs?

Mr Compton:

We have not cut any medical jobs. In the middle of this year, we have not found any major cuts applied to what people ordinarily see as key professional groups, which are the cornerstone of running the health and social care system. That is not the case.

Mr McCarthy:

A priority for action last year was that 100% of patients should not have to wait longer than nine weeks. This year, the target is for half of that, and the rest will have to wait 21 weeks. What is the rationale for changing that target? A lot of people come to us, as public representatives, to tell

us that waiting lists are too long and to ask what is going on. Yet here we are making things worse.

There is very little in your commissioning plan about the Bamford report. Are you on target with the Bamford report in respect of providing for people with mental health problems and learning disabilities? Will you be able to provide what the report asks for over the specified period?

Mr Poots:

The honest answer is that, last year, they set themselves targets that they could not meet. There is no point in being dishonest with the public and saying that the target is to turn everybody around in nine weeks when we know that we cannot actually do it.

Mr McCarthy:

Does that mean that we are admitting failure before we start?

Mr Poots:

It is not about admitting failure; it is about setting out where we are and what we are capable of delivering. Ultimately, there is no point in my telling the public that this is what we aim to do, when we fully know beforehand that we are not capable of doing it. I want to move away from targets to some extent and become more focused on driving change and improvements in how services are delivered. For example, we have a target that people will be seen in A&E within four hours. Ultimately, I want to ensure that everybody who goes in to an accident and emergency department is seen and attended to very quickly. If a bowser lands in A&E needing two or three stitches after being involved in a fight, it would not perplex me too much if he had to wait for more than four hours, provided that a person who was seriously ill and needed treatment got that treatment. Sometimes we get ourselves too focused and tied up on targets as opposed to outcomes. The outcome should be that, when people need lifesaving procedures, we engage in delivering them, and when people need some form of care, they should get that care. However, they may not always get it as quickly as they would like, and that can often depend on things that are outside our control. For example, someone going into A&E in January may wait considerably longer than someone going into A&E in September. That is the nature of life, and sometimes you will have to wait that bit longer when there are pressures. That is the bottom line.

Dr McCormick:

It is disappointing that we have not been able to sustain the previous targets. England has had a standard target, which is now enshrined in the NHS constitution, of being able to deliver what is called a total journey time — a combination of outpatient, diagnostic and inpatient treatment — of 18 weeks. We were doing quite well towards a set of targets, which was nine weeks for outpatient, nine weeks for diagnostics and 13 weeks for inpatient. If those were added together, it would be 35 weeks, compared with 18 in England.

It is disappointing not to be able to do better. However, the reality is that there has been substantial investment in capacity. Part of the problem has been capacity. Looking back, we tried to buy our way out of the problem by sending the excess waiters, so to speak, to independent sector treatment. That did not fully work because we were not getting to a stable position where demand and supply were in balance. Therefore, part of the issue is increasing capacity.

Recurrent investment is going in. For example, £17 million of investment is going in to build up the in-house capacity to provide better elective waiting times. However, the bigger point links to the review, and it shows that the way ahead has to be to manage demand much more comprehensively to build up the primary care side to ensure better prevention. The real improvement in waiting times will be achieved by whole system reform. That is very challenging and ambitious. However, I think that we have to acknowledge that there has been a degree of disappointment that it has not been possible to hold the standards. That area remains a considerable concern for both elective and A&E care. We need to ensure that we do all that is possible to deliver a standard that is acceptable from the public's point of view, especially when it is demonstrable across the water that those things are possible. We have to be realistic, and that is why this year's decision is to adopt the targets that are there. The fact remains that the vast majority of people are seen in a decent time. There are some areas where we need to continue to investigate and examine, because some waits are still unacceptable. We hear the concerns, and there is a degree of disappointment, but immense commitment is being shown by the trust team and the board as the performance manager to try to do the very best that we can in those contexts.

Mr McCarthy:

What about the Bamford provision?

Mr Compton:

We have some issues this year with learning disability services about whether we will have the full number of places available. That does not necessarily relate specifically to the health and social care system; it is to do with the other side of the house and the provision of places. At this juncture, we are on target to deliver this year what we set out for ourselves at the start of the year on both mental health and learning disability.

We are working very closely with other Departments, for instance with the Department for Social Development on the provision of social housing, on which there is interplay. For example, last year, we were a little late in the target because the opening of a facility was delayed for about four weeks, largely due to difficult weather conditions hampering final construction over the winter. However, there is no material problem at this juncture.

We have, and it can be seen in the plan, a simple statement of fact that we needed authorisation to commit some expenditure six-to-eight months ago. Because we did not get such authorisation six-to-eight months ago — due to the complexity of the Budget debates and discussions and not because people did not want to give the decision — there will be some slippage in that money in the context of this year. It is important to draw your attention to that, but it is articulated in the plan.

Mr McCarthy:

I am glad to hear that.

The Chairperson:

How much slippage?

Mr Compton:

I have so many numbers running through my head: let me look in my papers and tell you exactly what it is at this point. It is not mentioned specifically under deferral. I need to come back to you, but I think that it is in the order of £3 million for learning disability. There are a lot of numbers in my head; I think that it is in that order. I will confirm that with you.

The Chairperson:

Will that have a knock-on effect for the target of 45 patients resettled?

Mr Compton:

No. At this point, we do not have a particular signal that there is a problem. It is adjudged to be full-year-effect money, so the schemes come on board in the course of the year and do not spend the entirety of the money in any event. It is not as if all 45 places would emerge on 1 April. To spend the entire money, they would all have to have been there on 1 April. Those places emerge during the course of the year, but the money is set to one side because we know that the full-year-effect will run through on the following year. It is always better to do that than to run the services part-year and encounter financial problems the next year.

The Chairperson:

OK.

Mr McCarthy:

I am glad to hear what John said in relation to the mental health and learning disabilities. We are always concerned — and I am personally involved — when funds are under pressure. Such services are not high-ranking when it comes to publicity, but they always seem to be the Cinderellas of the Health Service that seem to be dropped somewhere. We want to keep on target, and I am grateful to hear that that is the case.

Mr Gardiner:

How can it be reconciled that none of the Minister's priorities, as set out in the direction, refer directly to the services for children and families? Further to that point, will you consider asking GPs to hold evening surgeries to take the pressure off accident and emergency units? An example of such a case might be that of a child who suffers all afternoon with earache or a high temperature. The mother waits for the father to come home, and then they rush over to accident and emergency, which takes up more time there than a GP setting aside an hour on certain nights of the week, or whatever, to deal with such cases. They used to operate that system but now it is all into hospital accident and emergency units. The old system might relieve a lot of stress and tension.

Mr Poots:

We must decide whether to stay with the nationally negotiated GP agreement or pursue our own agreement with them. Looking to the future, we had a report done in 2006 on the primary care

centres, which I believe to be a significant way forward to improve healthcare. I refer to the primary care centre that James Reilly told me about — the diabetes, chest clinics and so forth that such facilities contained.

For example, the one proposed for Ballymena, the site of which I hope to visit tomorrow, will cost £21 million. It will have diagnostics in it; it will have people who can read x-rays and so forth. Instead of people such as an older person with chest problems having to go from Ballymena to Antrim, they should be able to go to their primary care centre as opposed to the A&E in Antrim. They may then be referred to the hospital, but we would be screening out people because the GP will have the diagnostics carried out on-site to identify individuals' needs.

I would like to see a series of such primary care centres developed throughout Northern Ireland, and, in conjunction with GPs, we could negotiate with them about having the facilities opened beyond normal working hours. Lots of people out there may be concerned, perhaps about a growth on their skin or whatever, but are working a nine-to-five job in which it is not suitable for them to take time off work to check up on these things. Perhaps they cannot get that time off, and GPs are not available on Saturday morning or in the evenings. We must look at how those services are provided. I do not think that current provision is conducive to providing the best possible healthcare in Northern Ireland. I think that we are throwing an inordinate burden on to A&E units, and, as a consequence, a lot of people are not being seen as quickly as we would like them to be seen. Therefore, I am happy to negotiate with the GPs on that basis.

What do we have that we can offer the GPs? If GPs are in a fairly decent position where they are quite well paid and do not have to work out of hours to the same extent, and locums are stepping in and so on, what do we have to negotiate with? Primary care centres enable GPs to increase their earning potential by doing work that is currently provided by hospitals. We could have that work provided for us at lower cost than is currently the case with hospitals. There is a potential for GPs to negotiate themselves into a better financial position while providing a better service. If the quality of service increases, I do not mind, particularly if it is done at a lower cost than the hospitals are currently providing.

Mr Gardiner:

It would be better, safer and less expensive in the GPs' hands.

Mr Poots:

Sorry, I did not cover the question about children's services. Most of those are statutory services and remain a priority. They will be fully reflected in the indicators of performance direction, which will be used to performance manage the trusts. They have not been forgotten about, but they are a statutory responsibility. Legally, therefore, we cannot forget about them.

Mr Gardiner:

They will be in your next report.

Mr McCarthy:

Correct me if I am wrong, Minister, but did the Department not recently provide extra funding, which has since been withdrawn, for out-of-hours GP provision? I have had that drawn to my attention in my area, where the GP stopped working at 5.00 pm.

Mr Compton:

This goes back to the historical negotiation of the new general practitioner contract, which gave the option for general practitioners to opt out of the 24-hour service provision. As a consequence, the health and social care system in Northern Ireland now invests some £20 million per annum in out-of-hours services across the Province. Those are run differently from the way in which they were run in the traditional or shared practice model. There has been no substantial reduction in the amount of money spent on out-of-hours services.

Mr McCarthy:

Out-of-hours provision is different from extra hours offered at the GP's surgery. Out-of-hours services deal with an emergency. In my area, the GP was able to do a few hours after 5.00 pm to accommodate workers coming home because he had extra funding from somewhere. That was taken away and that service has gone.

Mr Compton:

This goes back to last year when there was a debate about the overall efficiency of the services. The view was that general practice was no different to the rest of the system in that it had to bear some of the efficiency targets that were presented for the total system. From memory, I think it was around £5 million across the entire system. We contracted GPs through a set of specific tasks that we asked them to do and they were remunerated on that basis. I am not aware of us

having taken a decision that caused significant detriment in any way to individual general practitioners, and we are very closely involved in this.

There are different views about that, and there are two sides to every argument. Some will tell you that we did various things, but we have had to live within the money that we had, and that led to those decisions being taken.

Mr Gardiner:

A child with a sore ear or an upset stomach would not have to wait for four hours to be seen by a GP as would be the case in an outpatient ward.

Mr Compton:

That is slightly different. I reinforce and support the Minister's point that primary care partnerships are a key component of the plan. Their purpose is to get general practitioners working in a different way in groups and to give them the incentive to deliver services locally and differently. That will be supported with more modern accommodation, as described by the Minister.

Mr Gardiner:

It would only take an extra hour in the evenings, say between 6.30 pm and 7.30 pm.

Mr Poots:

We are currently stuck with the contract that was negotiated, and, to be honest, I would not send the person who negotiated that contract to the garage to buy a pound of butter for me. That contract gave GPs more money for fewer hours, and I could never understand why the Government agreed to it. As things stand, we must live with that contract, but we must change it fundamentally. In some GP practices, you could wait 10 days or two weeks for an appointment, which is unacceptable. You would almost need to make the appointment first and become ill afterwards. That is not an acceptable service, and all of that must be challenged and changed. Obviously, it will take time to do that, but we are aware of the issue and want to deal with it.

The Chairperson:

That was the point that I was going to make. My husband's GP is in Dungannon, and he might wait two weeks for an appointment, but my practice in Tynan seems to have a much better system

of managing its workload. People go to out-of-hours GPs because they cannot get an appointment with their GP during normal hours. They are prepared to take time off work to take a sick child to the doctor, but they cannot get an appointment, and out-of-hours surgeries often provide for the spillover. Do we have enough GPs to cover our needs?

Mr Compton:

Yes. There is no question about the total numbers of GPs. The issue is one of creating a different relationship with general practice. The Minister is correct in saying that many GPs want a different relationship and the opportunity to establish that. The argument should not be presented as us versus GPs. It is a matter of establishing primary care partnerships, putting collections of GPs together, giving them some responsibility for the totality of what they do and enabling them to influence how the services are shaped and developed. The Minister is very supportive of that notion.

Individual practices have the right to determine how they operate. Our expectation is that individual practices will have emergency appointments, and the majority of GPs will run emergency clinics. Sometimes, the problem is that patients want to see a particular GP in the practice, which may mean having to wait. However, if they are prepared to see any GP, they may not have to wait for the same length of time. That is patient choice. When patients form relationships with individual doctors, they want to see that doctor. It would be better if we had a much more streamlined system, and part of the design of the primary care partnerships has focused on that. The pilot schemes worked quite successfully. In the west, for example, they were able to change the arrangements for reporting ultrasounds. It has become a much better system for patients and GPs, and we want that to be explored and developed further.

Ms Boyle:

Minister, there are no priorities for action (PFAs) for the Northern Ireland Ambulance Service. Are there plans for the service for 2012 and beyond?

Mr Poots:

Obviously, the Ambulance Service came under a lot of change over the past number of years. It has had many fairly stringent targets to meet. A lot of their responses are now made within an eight-minute time frame. Sometimes, I am curious as to how some of those are achieved and why those given the higher priority are accorded that. Perhaps, because the ambulance is stationed

close to where the patient is, they are given that priority in the first instance. You can be a little sceptical at times.

Nonetheless, the service has seen tremendous change over the past number of years; for example, getting to grips with the RRVs. We are getting better service from the Ambulance Service than we got a number of years ago. However, there is more to do and we will seek to address that.

For example, we now have a GP in the ambulance station to which calls are made. He can give his views on the nature of the problem and will, on occasion, be able to talk to the people who have rung for an ambulance.

One of the other things we are looking at is a telephone number that is non-999 and which may deal with people who require care of some kind, but not emergency care. We need to look at that. The question is this: do we do that in conjunction with the police or other services?

In essence, the Ambulance Service is as it is and there are no spectacular plans for change over the next year. One of the things I mentioned today in my conversation with James Reilly was the issue of the air ambulance, and how air ambulance — I suspect that this is of special interest to you as you represent West Tyrone — may be provided for the north of Ireland in this instance, as it will cover Donegal as well. It is something that James Reilly is interested in moving forward. We will continue to have those conversations. At the minute, the Ambulance Service says it does not require an air ambulance; but it needs to be challenged and tested as to whether that is the case. It there is a major trauma incident in Gortin, what would the travel time be to the Erne Hospital at Enniskillen or Altnagelvin Area Hospital? Portaferry is another example. If someone in Portaferry has a serious illness, how quickly can he be got to the Ulster Hospital at Dundonald? There are a number of areas in Northern Ireland that lie on the extremities, and we need to look at that and address it, particularly if we are to offer cath lab services to more people who have suffered major heart attacks and so forth. We cannot offer those at nine hospitals. We may not even be able to offer them at three hospitals. Do you need an air ambulance to get those incidents to hospital within the hour?

Ms Boyle:

So the air ambulance is something that can be looked at for places in West Tyrone such as Gortin,

places like Aghyaran and further afield? These are particularly rural areas of West Tyrone which are difficult to reach, depending on the time of year. This is a concern in rural areas and that is why I raise it.

The Chairperson:
Can I have two minutes?

You can understand why this document provided fodder for the media. In the foreword, it states that we have too many acute hospitals and we should think of scaling back from 10 to between five and seven. However, in this document, you — not you, Minister, but John I hasten to add — have not put any meat on the bones. That raises great concerns for many of us who have been through serious rationalisation of our acute services in the past.

You also refer in this document to A&E waiting times. I know that you want to talk to us about that. You referred to A&E types 1, 2 and 3. What does that mean? Does it cover all A&E units? Are A&Es now classified as gold, silver or bronze? What is the explanation of types 1, 2 and 3? Should we be worried about areas that are hanging on to acute services by the tips of their fingers?

Mr Poots:
There has always been a classification of A&E units. In reality, the Royal's A&E unit is the only one that falls into the top classification, because it has a trauma unit. John, do you want to explain the different classifications?

Mr Compton:
The explanation of types 1, 2 and 3 is very straightforward. Type-3 units deal with minor injuries. Type-2 units are what people describe as casualty units, because they deal with a degree of serious conditions but not the most serious. Type-1 units deal with the full range of conditions — the remaining 5% of the 95% rule — that may then be treated at the regional trauma centre if they are big things. If you count children's units as type-1 units, even though they are a separate thing, we have 11 type-1 units, two type-2 units and six minor injury set-ups running across the Province.

Again, on the point about being straightforward about the commissioning plan, we often get

and have received criticism in the past for not saying what we mean. I think that what we were trying to do in the commissioning plan was to stimulate debate and to say to the population, "Look, we have between 1·7 million and 1·8 million people. We have a hospital infrastructure that is this way, but is it the right infrastructure? We are asking you that basically because it is getting increasingly difficult to run that infrastructure in the way in which it is currently set up for a whole range of reasons, starting with the issue of quality and outcome". The debate is about the nature, type and number of hospitals. It is not about money, it is about quality, outcome and sustainability. That is really the issue. We have to get to the point where we talk about how a population can reasonably access those services so that there is a good-quality outcome and that the services being accessed are safe and sustainable. We have a number of examples of where those issues can overwhelm a system and lead to all sorts of complexities and difficulties.

The Chairperson:

Is the plan for this year the place for that kind of statement? There is not going to be any Hayes-type report, because presumably that is what the review will be doing later on. This document is about planning for the services being commissioned for the rest of the year.

Mr Compton:

It is also about moving towards the implementation of extant policy, which includes policy that was written by Hayes. The extant policy is about moving towards that type of thing.

What we do with the commissioning plan is we say to the providing organisation, "Tell us how you can provide a safe, sustainable hospital service for your population, how you would go about doing so this year and whether you would wish to make any changes". They may say that they do not want to make any changes or that they want to change this and that. We mentioned in the commissioning plan, for example, some rationalisation of single site specialties so that we do not have hospitals running similar services cheek by jowl but have all services on the one site, because that is more efficient. The organisations then come back to us saying, "This is how we would respond to your commissioning plan". All of that is, of course, superseded and entirely subject to ministerial decision.

From the board's point of view, it is not correct not to say what you think and not to discuss the sorts of issues that are real, that need to be raised and that need to be in the public domain. Part of what we as a commissioning organisation are supposed to do is to do that in a transparent

manner, and if we do not do so, we get criticised from the other side for not doing it in that way.

The Chairperson:

At the same time, it is sometimes hard to see where the balance is. A paragraph in the paper that we received states that more powerful local commissioning groups will have a crucial role in driving change. Will that not run the risk of creating more of a postcode lottery?

So, depending on where you live, you will or will not be offered bowel screening or PV testing. Those things need to be done for the benefit of all the population, yet you are putting local commissioning groups in a position where they are making decisions. Do those decisions that apply to everybody not need to be made at ministerial or departmental level?

Mr Compton:

Yes.

Dr McCormick:

The balance is achieved by the Minister specifying a commissioning plan direction and a performance indicator direction and outlining what is expected across the region. If a local commissioning group wants to do something additional and distinctive, it is entirely at its discretion. However, it would have to achieve the regional standards and the regional specification that is set. That should be achieved for all.

We can be sure of avoiding a postcode lottery by making sure that the resources are allocated fairly across the region. That is why we gave a fair degree of attention to a capitation formula. The money is divided up according to the needs of the population, and each LCG can commission using that resource. There is discretion for them to adapt to the specific needs of that area, but that should be informed by local views. That is why the LCGs are inclusive and include local representatives as well health and social care professionals on their leadership. So, there is an important specification at regional level. Most of the things you mentioned should be achieved uniformly across the regions. That is the way it should be.

Mr Compton:

I want to re-emphasise that LCGs are committees of the board. They are not stand-alone organisations, and, therefore, they operate within the total framework of the board. The Minister

tells us the direction of travel he wants and outlines the targets and what he wants delivered. We then tell the commissioning groups what they must work towards. For example, the organisation of mental health services may vary in rural areas and urban areas. We expect local commissioning groups to take account of that local flavouring, but we expect the population to have access to inpatient treatment. It is not a question of one local commissioning group deciding to not run inpatient treatment. Everybody has to have access to inpatient services. However, delivering day support in a day care system in a rural area might be quite different to that in an urban area because of geography, travel and distance. So, we expect local commissioning groups to take account of that in how they work those issues out. They are very clear about that; there is no question of them wanting to run as a separate entity.

The Chairperson:
Are they mandated to look across government? We talked before about joined-up government and about working better together. For example, the whole area of rural transport is under the Minister for Regional Development and is a lifeline for people in areas where there is no public transport system to meet needs. People who go to day care facilities could access the rural transport network, create a cheaper way for our clients and patients to access services in rural areas and help to sustain a very important service in rural areas. I raised that with the previous Minister when the taxi contract was being talked about, and we felt that that could be done much cheaper, provide much better value for money and, at the same time, improve the service. Have there been any discussions on such areas?

Mr Poots:
Catherine Mason would be very interested in talking to the Committee about transportation. We are the Department of Health, Social Services and Public Safety, and we should not spend millions of pounds transporting people as we currently do. It seems somewhat perverse to me that the Department pays for taxis to and from hospital for people who receive a disability living allowance (DLA) car. So, there are areas that we certainly can look at and address.

Local commissioning groups offer much more potential to provide the right services at the point of need. Obviously, people in Belfast have different requirements from people in the Western Trust area. Looking to the future, and community planning in particular, I see great potential for the community planning process to engage much more strongly with the commissioning process to ensure the right health care provision for each area. There is

significant potential to develop that further as the review of public administration rolls out and community planning moves forward. I am very happy to work with councils on that front.

The Chairperson:

I want to go back to the comment that the Department of Health, Social Services and Public Safety should not be spending millions on transport. There is a way in which much less can be spent much more effectively, while acknowledging that we do not all have the luxury of being able to walk to access health services or having a proper public transport service to help us to do so. A certain level of spend is needed, but that can be done in a way that makes more sense and improves the service.

Mr McCarthy:

We are nearly finished, but I want to follow on from the furore about the possible closure of acute hospitals, which we heard this morning as we got out of bed. Your document states that we are entitled to only five or six acute hospitals, but we have 10, so three or four acute hospitals are in somebody's sights. John said that doing away with those is not a matter of saving money. If it is not a matter of saving money, but the policy, as I understand it, is to provide local services for local people as far as is ever possible, why would you want to close any acute services? You have already raised fears. This morning, people talking about the loss of acute hospitals turned the airwaves blue.

Mr Poots:

Let me be clear that "local services for local people" is not good terminology. Appropriate local services for local people would be much better. For example, every hospital in Northern Ireland cannot have a catheterisation lab with a 5% return of people dying from heart attacks instead of a 12% return. We would not get enough consultants to man them. We simply would not have the capacity or money to do that. Nor could there be a cancer centre in every local hospital. The regional cancer centre is at the Belfast City Hospital, and we will expand services at Altnagelvin. The regional centre has provided much better results in cancer care. We do not have a paediatric unit in every local hospital, nor should we. We are looking at providing a greater degree of primary care to bring services to people locally. Under the same roof as GPs there would be allied health professionals, dieticians, physiotherapists, occupational therapists and all those needed at a local level to provide the appropriate local service. However, not every hospital will provide acute services. If Northern Ireland's population was four or five times its current size, we

would, perhaps, have the ability to do that. However, with a population of 1·7 million and travel times of less than an hour in most instances, we will not be able to provide that type of service. If we attempted to do so, it would be to the detriment of the health of people in Northern Ireland.

The Chairperson:

We are not expected, I presume, to close between three and five hospitals between now and the end of the financial year. However, Minister, in fairness to Kieran, there is no question that the appearance of that comment in the foreword to the yearly draft commissioning plan created fear.

I know that you want to talk to us about junior doctors, but throwing out a comment such as that and leaving people to think the worst creates an atmosphere of fear. As elected representatives, that is what we do, because we are thinking of services in our areas and how our constituents might be affected. We are talking about services for this year. We have established that there will be no further consultation and that this, therefore, is the plan for this year. We will be keen to talk to you again in September about the next stage of commissioning services and the review as outlined.

It will be hugely important to know what level of consultation is taken on those big decisions and how well we plan for the future. Minister, I am sorry that that session took longer than planned. Would you mind going over the issue that you wanted to talk to us about at the beginning of the meeting?

Mr Poots:

That is not a problem. It is an immediate issue regarding the provision of A&E services in Lagan Valley Hospital and in the Belfast Health and Social Care Trust. As I indicated a couple of weeks ago, it became apparent that there would be a shortage of junior doctors from the beginning of August, which would cause specific pressures on A&E units. Those pressures will impact on the provision of services in a number of hospitals within six months.

In the interests of patient safety, immediate changes will be required. Thereafter, there will be a broader strategic look at how the system delivers A&E services. The trust has considered all of the available options in respect of the Lagan Valley Hospital, but the inevitable conclusion is that the opening hours of the hospital site will be restricted from 3 August 2011. Further details of those arrangements will be available to me at the beginning of next week when I receive a full

report from the HSCB and the PHA.

I understand that further immediate work will be required in the Belfast Trust to enhance the training and supervision arrangements for junior staff. That is under discussion in the trust. There was criticism because there was not enough supervision of junior doctors in the past, particularly in the early hours of the morning. However, the overall position regarding A&E services in the Belfast Trust will remain unchanged until October this year. Any major changes regarding the reconfiguration of A&E across all the Belfast hospital sites will require consultation. I shall ensure that there is effective engagement and transparency in that process, and I will keep the Committee updated.

The Chairperson:
Thank you for that, Minister. None of us wants to see a situation in which there is not adequate supervision. We do not want to put young people in a position of responsibility for which their training and experience does not qualify them. We need to ensure that people who attend our hospitals, whenever that is, do so safely. What exactly does the supervision issue on the Belfast Trust side mean? Are we likely to see a scaling back of service in one or more of the hospitals in Belfast?

Mr Poots:
There are currently four hospitals in Belfast. The Ulster Hospital essentially serves east Belfast and out towards Strangford and north Down. It has been under a huge amount of pressure over the past couple of weeks in particular, and that is ongoing. We then have three hospitals — the City Hospital, the Royal Group of Hospitals and the Mater Hospital — that are within approximately a mile and a half of one another. Most cities have one hospital that provides services and one A&E unit. It is not our intention to go down to one A&E unit, but I think that we will have to look at the provision of A&E services across the city. I think that we will end up going down from three hospitals to two providing A&E services out of the three latter hospitals that I mentioned.

To achieve the best possible A&E care, essentially, in a quality A&E unit like the Royal, you require eight consultants. They will provide 24-hour cover, with two consultants available at all times. That is not currently the case, but it could be the case should we engage in a rationalisation. Junior doctors will always serve under a consultant; you do not want a junior

doctor making the decision where you want a consultant making the decision. That is not always the case for patient care at the moment. We can make that the case should we engage in a rationalisation process.

In my opinion, however, any such rationalisation must be carried out in a structured way that is thought through, explained and prepared for, as opposed to something that is thrust on us. That is where I see some problems in what is proposed for Lagan Valley Hospital. We are doing what we are doing there on the basis that there are not enough junior doctors to fill the positions. That happened in Tyrone and elsewhere previously when the decision was taken out of our hands and was taken by the clinicians who make clinical decisions. They said, "We cannot do that, because it would be clinically dangerous to do it; therefore, this is what has to happen." I do not want us to be in that position when it comes to the rationalisation of the three hospitals in Belfast. I want us to make the decisions based on the best evidence that is available and on how we can best provide those services.

The Chairperson:
Minister, hopefully there will be a proper amount of planning to enable the hospitals that are still providing A&E services to deal with people as they come through the doors. That is what we saw in Tyrone in the past. I appreciate that you are saying about Lagan Valley Hospital that you are having further meetings and that you are not in a position to give any further clarification on that matter at this stage. However, when it comes to the Belfast hospitals, you and I both know that as soon as we go out of this room, you will be asked what that means. People have been talking up the position of the Mater Hospital, and you will be asked whether the A&E in the Mater will close. Is that not the case?

Mr Poots:
I have no plans or proposals to close the A&E in the Mater Hospital.

The Chairperson:
Do you have plans or proposals to close the A&E units in any of the other hospitals?

Mr Wells:
He is going to go through them one by one.

Mr Poots:

We did not really want to get to this position, but I do not do lies; I cannot respond in any other way but to be upfront about things. The Royal Victoria Hospital is the regional trauma unit, so its position is secure. Belfast City Hospital has been moving more and more towards planned surgeries and procedures. Ultimately, that is probably where we see the City Hospital. The Belfast Trust is working on this issue at the minute, so the proposal has not been put to me. The trust is working towards the position that more elective surgery will take place at the City Hospital and that more emergency procedures will take place at the Royal Victoria Hospital. That is a perfectly logical position, because it means that fewer people will have operations cancelled.

As a consequence, then, the services that are provided in the emergency care unit in the City Hospital would be associated more with the specialisms that it engages in. So, someone who needs stitches or has a fracture would more than likely be sent to the Royal, whereas a patient who turns up in the Royal requiring neurology treatment would end up going to the City. Therefore, a different kind of service would be provided; it would not be the type of A&E service that is currently provided. It will be a service that meets the skills of a hospital that provides specialist care.

The Chairperson:

If the A&E as we know it is no longer to be provided in the City Hospital, the other hospitals in Belfast could take up the slack from that and the City Hospital could concentrate on non-blue light elective procedures, such as those for cancers and the specialisms that the City Hospital already provides. The City Hospital's current A&E complement of doctors, consultants and junior doctors could be relocated to either the Mater Hospital or the Royal so that proper supervision and staff levels are available at all times.

Mr Poots:

That would enable us to provide the proper supervision of junior doctors where people are getting the right kind of care. My concerns are about physical capacity. For example, on a January evening in the Royal when the 25 available beds are already in use, how do we absorb more? I need some convincing on that issue to ensure that the physical capacity of the hospital can deal with the numbers of patients that are coming through. So the medical complement may be available, but it needs to be operating in a space that is suitable. One of the issues affecting

Antrim Area Hospital is that the space that was originally planned is not suitable for the numbers of people who are attending. We cannot ask people to do their very best in providing healthcare if they are not operating in an appropriate unit.

Dr McCormick:

As the Minister said, the Belfast Trust is working up the detail of what it is going to do over the next number of months and will need to report back to the board, its commissioner and the Minister. That process has to happen reasonably quickly. If we are looking at some sort of change in October, there needs to be very careful planning, as everybody is saying. There is a lot of detail to work through and a lot of people to consult and engage with to make sure that there is good planning and good confidence building. The outcome has to be sustainable and effective through the winter and beyond. It is the responsibility of the service to make sure that the capacity issues — physical and staffing — are dealt with properly and thoughtfully, that a good plan is developed and that there is a brief consultation.

There will not be the full eight-week consultation, but there will be a period of consultation, which probably means that something might be issued by way of a formal proposal, possibly before the Assembly reconvenes on 7 September. Something substantive may go out with a fully detailed proposal before too long. That will be done to achieve exactly what everyone is asking for: a good and orderly transition and an assurance to the public that the emergency departments across Belfast will be effective and will meet the needs of the population, given that there is a local population to serve and a regional responsibility.

One of the points of having the Belfast Trust was to move away from a situation of having three or four different hospitals close together and operating as separate entities. We want to think in terms of one service with several sites: a unified emergency service on different sites, making use of the physical and staffing resources across those sites. That should produce a good outcome for the public. The trust is working very hard with its own people, all its stakeholders and the trade unions to develop a coherent and proper transition. It is important that it is done very well, and that is what we are all trying to achieve.

Mr Compton:

We want to commission a safe and sustainable emergency service for Belfast. When we have talked about emergency departments as part of the commissioning plan, the root of it has been

that the departments would come back to us with proposals for how to implement the transition. Those proposals will include whatever changes the departments think should be made. At that point, there has to be an agreed position from the commissioner and, ultimately, an agreed ministerial position. That has to take account of ordered transition.

The worst place for us to end up would be in a situation where these things happen because they happen and there is no organisation or planning. It may be that the organisation wants to make the transition at a certain time, and perhaps we will have to do something to buy some more time to effect the transition correctly and responsibly. If that is the case, as a commissioning organisation, we would make that recommendation to the Minister and would take the financial risk of supporting that if it was a matter of finance.

Ultimately, the change in care for accident and emergency is driven by quality. When 42% of people who go to our accident and emergency departments are classified as level 1 to 3 — in other words, they have a serious problem — it leaves 58% who go there with minor problems. That is not the full story because, sometimes, when you first turn up, you might have a major problem. For example, someone who went over the top of their bike's handlebars, split their head open, needed nine stitches and was knocked out could have a serious head injury, so it is quite appropriate that they are screened to make sure that they do not have one. However, there is definitely a different way of handling a substantial number of the 58% of people who attend accident and emergency departments with minor problems. The Minister alluded to that in his comments on a different way of handling primary care. So, it is important that this is done in an orderly and transitional manner.

You are right that there will be a lot of interest in this particular part of the debate, so the key issue is that there is information to come, preparations to be made and decisions to be taken. We are not at that stage yet.

The Chairperson:
I welcome the fact that the planned and managed process is happening. I think this type of rationalisation is the right way to go: it is eminently sensible when we have four, five or six hospitals providing the same level of services within a 20-minute radius of one another. That is my personal opinion: we will hear from other Committee members now.

Mr Wells:

Minister, unless Darren Clarke wins another major tomorrow, I think what you have just said will probably dominate the headlines. As someone who recently enjoyed the benefit of treatment at A&E in Lagan Valley Hospital courtesy of a rogue election poster, I was conscious that, even on a Thursday night, there were quite a number of people in the A&E department at 2.00 am. Have you had any discussions with neighbouring hospitals as to which of them is going to take up the slack if there is to be any curtailment of the A&E services at Lagan Valley Hospital? Will patients have to go to the Royal or Craigavon hospitals? Where do you envisage them going?

Mr Poots:

The major issue of concern is that the A&E unit in Lagan Valley Hospital is not small. It deals with 33,000 people a year; 29,000 people who call in for services and 4,000 who attend for reviews. That is a fairly considerable number. If the proposal for 9.00 am to 5.00 pm were adopted, that would accommodate 52% of the people who currently use it, therefore dislocating 48% of users. There is the potential for more people to attend between 9.00 am to 5.00 pm who may otherwise have left it until later. It may be because they are not in need of accident and emergency services but require some care and treatment. The number could potentially be raised, but it would still displace around 16,000 people as a result.

When the A&E unit at the Mid-Ulster Hospital closed, people who previously attended that particular unit did not turn up at the Causeway or Antrim hospitals. In the case of the Whiteabbey Hospital, they did not turn up at the Antrim or the Mater hospitals. When a local A&E unit is closed there seems to be a drop off of people who actually made attendances at the hospital. One would assume that not all of those people will attend. As the Lagan Valley Hospital is in the South Eastern Trust, I do not expect that people will end up going to Dundonald. I do not see any particularly reason why people would drive down the Hillhall Road, up the Knock dual carriageway, turn right at the traffic lights and go to Dundonald, which would take around half an hour to 40 minutes.

Mr McCarthy:

I cannot let you get away with this, Minister. You expect people from Portaferry to drive to Lagan Valley Hospital to get mental health provision, when someone took it away from Dundonald? What is good for us is good for Lagan Valley.

Mr Poots:

I am indicating that I do not anticipate that people will do that. I anticipate that they will drive straight down the motorway to the Royal or straight up the motorway to Craigavon. If you live in Moira, you would not go to Dundonald; you are more likely to go to Craigavon. If you live in Derriaghy, you would not go to Dundonald, you would go to the Royal. Ultimately, my opinion is that the pressures will be applied to the Royal and Craigavon hospitals in that instance. Perhaps John would like to respond as to what negotiations have taken place there. It causes me concern.

Mr Compton:

As we meet today, a detailed meeting is going on to look at the current state of play around the workforce of Lagan Valley Hospital, and what the implications of change would be. The implications for the units that would have to accept some patients who would previously have gone to Lagan Valley are being considered. It is very important that whatever the decision is, it is sustainable. There is no point is our coming to a decision that would require us to come back two weeks later and say we had tried to do one thing, we could not do it, and that we have to do something differently. We have to start from a platform that we can definitively stand over.

There are some final interviews to take place with regards to staff who have applied for post. Those are not fully through yet, and on that basis, the Minister is quite right that we are expecting to hear a definitive statement at the end of the week. Given the timescale involved, with 3 August being very close, we have to call this, and the final position will be known at the end of the week. It is reasonable to conclude that there will be changes at Lagan Valley. However, it is a matter of their extent. From a practical point of view, there are only three levels of change: close at 10.00 pm or 11.00 pm and run through the night; close at 5.00 pm; or leave as is. It is not as though there are 101 permutations; there is a range of decisions. As a commissioning organisation, we made a precise request to the providing organisation. We asked it to test to destruction the ability to maintain the unit open and tell us what the issues are. We asked for that to be done in a phased way through rolling back on the hours. A final point will be arrived at, we will give the Minister that information, and there will be a discussion about what happens thereafter.

Ms P Bradley:

As the elected representative for North Belfast and someone who lives on the periphery of the area, may I selfishly say that I welcome what you have just told us? There has been a lot of

scaremongering today about the Mater Hospital. After the loss of A&E services at Whiteabbey Hospital, many who live in North Belfast and the Newtownabbey side of North Belfast saw that as a potential double blow for the area. Thank you very much for allaying that fear.

You said that A&E departments get clogged up around January, and we also talked about the supervision of junior doctors. I would like to think that the correct ratio of consultants to junior doctors would result in the quicker turnover of patients in A&E departments. I know that there are only so many decisions that junior doctors can make. They cannot discharge a lot of patients, and many patients must wait for a consultant's say-so. Better management of that ratio and increased supervision of junior doctors might create a more positive situation for A&E departments at any time of the year. Therefore, I welcome the fact that junior doctors would receive a greater amount of supervision. It would help in the long run.

Mr Poots:
It might be useful to the Committee, Chair, for John to set out what the ideal structure for an A&E unit would be and what the current structures are in some A&E units.

Mr Compton:
The main accident and emergency department is the type 1 unit. Ideally, we would have eight consultants working in that unit. Currently, no unit has eight consultants. We want consultants to be supported by larger units of about 14 middle-grade staff, but we do not have 14 middle-grade staff anywhere. One difficulty is that we do not have enough senior decision-makers close to the point. Performance in some of the larger A&Es in England is very good on four-hour and 12-hour breaches. That is not an issue there in the same sense as it has been here. We are looking for up to a dozen or so junior doctors in our larger units, but we do not have that number anywhere. We do not have the staffing complement.

I say that this is not a financial problem because there are 10 units, excluding those for children for a moment, and it is simply not possible to put together that package of staff. Even if we had the money, we could not get the staff. Where people go to work is determined by the volume of work. It is important for the debate to be about the level of emergency care provision that the population receives. Everybody is loyal to a particular facility — that is a fact of life. However, the real debate is about the emergency service available to a population, and we have to elevate the debate a little to that level. That said, it is important to put on record what our A&E

departments do. Sometimes, they get very bad press, but they see around 675,000 people each year and have only about 56,000 reviews. They see a great number of people.

If you look at what happened right across the Province, you will see that 1·1% of people waited up to 12 hours. I know that there are particular weeks of the year, often around winter, when it is particularly difficult, but it is sometimes presented in that way. I think that it is important for the staff who work in those units that we also put on record that the vast majority of people who go through the system receive appropriate staff intervention in a timely way. If we are making changes to our emergency services provision, it is also important not to suggest that that implies a criticism in some way of what exists. Our emergency system evolved and emerged from a different time, and we are looking at another system going forward.

It is not about saying that what people are doing on the ground today is bad or poor; it is simply that a more modern response service and modern system needs to be reflected. If you talk to senior professionals across the emergency field, and certainly to those who are involved in organising and managing it, you will find that everyone recognises that a change is important and should happen. However, they also recognise the absolute importance of doing that in a controlled, planned and sensible manner. Their overriding concern is that, if we do not take the decisions to do that, the change will happen in a disorganised and disjointed way, which will result in poor patient care.

Mr McCarthy:

The main problem seems to be the shortage of consultants and junior doctors.

Mr Poots:

Junior doctors.

Mr McCarthy:

Is there no one in this country who can plan? The population has been growing over a number of years, and it continues to grow. Is there no co-ordination between universities and the trusts to ensure that enough young people are coming through with the qualifications? If that does not happen, it is not unknown for trusts to go to other European countries to get benefit from there.

Dr McCormick:

That has all been tried. In the past couple of months, there was a major attempt to recruit across Europe. A number of years ago, the intake to the medical school at Queen's was expanded, and, very soon, the larger numbers of students will be reflected in the number of junior doctors. We have a difficulty at the present time, just as, some years ago, workforce planning did not match supply and demand and was out of line. As doctors from the new numbers coming through the medical school become available, that problem will diminish in the next few years. Further changes in the system of planning will mean that we will get to a more stable position, but, this year and last year, we had quite a significant mismatch. Junior doctors need to get the right training, and an element of choice is available to them across the UK. That is part of the nature of the way the world works. The agencies have tried very hard to recruit across Europe, and that has been a major drive this year and last year, but it has not been fully successful for emergency departments.

Mr Poots:

A number of issues have conspired against us. First, under the European working time directive, junior doctors are not supposed to work more than 48 hours a week. Previously, they worked considerably longer than that. I do not support going back to the situation where junior doctors worked 120 hours a week. I witnessed that, and people were absolutely run off their feet. Nonetheless, if a junior doctor were allowed to work for longer than 48 hours a week, you would have a better trained junior doctor at the end of the period.

We are constrained by a European directive on that front. Again, Europe indicates that we should not bring in workers from outside the European Union. Traditionally, Commonwealth countries supplied a lot of doctors to Northern Ireland and to the UK in general. We do not have the same ability to go after doctors from places such as Malaysia. We have to trawl Europe first. The Northern Ireland Medical and Dental Training Agency (NIMDTA) was trawling on behalf of the UK. It is not just a Northern Ireland problem; it is a problem for the rest of the UK, with the exception of the south-east. Given the numbers of people who live in the south-east, that region scoops up all the best young students —

Mr McCarthy:

There are golf courses there.

Mr Poots:

There are good opportunities there. A junior doctor could come out of university and be offered a job at Erne, Causeway, Lagan Valley or St Thomas'. Let us be honest, if you have done really well at university and want to develop your career you will take your opportunities. Indeed, at that stage of life, you would probably be foolish not to, because you can come back and be a consultant thereafter. This is what we are up against; and, unfortunately, it has led to a shortage of junior doctors in units across Northern Ireland. The problem was particularly prevalent in the Causeway and Lagan Valley hospitals. The Causeway Hospital will manage the problem because it has a group of locums who have provided support for a number of years; so it will be able to contain the problem. However, the Lagan Valley Hospital is not able to contain the problem.

Next year, the scenario will be a different, because 250 students will come out, so there will be a much better match, although the problem that those 250 students will have once they have trained as junior doctors is that there will not be jobs for them all. There is another problem with matching. The best solution would be for junior doctors to be allowed to work more hours, and I know that, at national level, people are talking to the European Union about amending the working time directive to allow junior doctors to work more hours. You can bring out more junior doctors to meet current needs, but you will then have too many doctors not being offered jobs. Alternatively, you do not have enough junior doctors. The working time directive is the biggest problem that we face.

Mr Durkan:

Minister, you touched on the circumstances in a couple of hospitals from different board areas, so I make no apology for being parochial. In particular, given its historical difficulties in attracting junior doctors and consultants, I would like to ask you about the Western Health and Social Care Trust area. Is there any danger that the measures being applied at Lagan Valley Hospital and the rationalisation of services in Belfast will be replicated in the west?

Mr Poots:

The good news for you, Mark, is that Altnagelvin is fine. I think that the Erne Hospital might be down one —

Mr Compton:

The Erne Hospital is OK as well. At this juncture, we do not have an immediate or pressing

problem in that part of the world. In the Erne Hospital, a slightly different staff structure between staff grades and training doctors helps the situation. At this point, there is no particular issue in Altnagelvin Hospital. However, if you were to talk to staff there, they would say that some of the difficulties that patients experience there are attributable to the fact that, inherently, they do not have the right overall constituent staff component.

It also worth noting that, when junior doctors qualify, they have a choice of areas in which to work, and there are three disciplines in which there are always fewer who want to work: emergency departments, obstetrics and paediatrics. I do not know what that says about training or what it means, but that is the reality. As the Minister pointed out, on this occasion, unless something occurs later today or tomorrow, there is an apparently insurmountable problem pertaining to the Lagan Valley Hospital. We have made it very clear to the South Eastern Health and Social Care Trust that we expect it to be able to demonstrate to us how it has tested to destruction its ability to leave the service as is and allow us to carry out a much more measured and planned change. With respect to Belfast, we made it quite clear that, should there be changes, they will have to happen in an ordered and disciplined manner.

The Chairperson:

Is any work being done in Queen's University, where we train new junior doctors, to give them a greater focus on those three areas, because it is very important that we get the best people in paediatrics, obstetrics — women and children: I have no difficulty with being gender specific on that one — and emergency departments. I understand why it is difficult to encourage people into those three areas. Obviously, there is the working time directive issue, and people do not get a handy 9.00 am to 5.00 pm rota in any of those areas, but we need good people in them. What is being done to encourage our complement of trainees?

Mr Compton:

There is very strong encouragement, and, of course, there is a mandatory requirement on everybody who is training to rotate through those areas. It is about long-term career choices. Junior doctors are applying for long-term career positions.

Sometimes, junior doctors will do their first stage of training in those areas because they want to become general practitioners. Training in paediatrics or obstetrics is a very good thing to do if that is how they intend to serve their membership. However, this is about encouraging people to work long term in those areas and to regard them as areas for long-term careers. A huge amount

of effort goes into the way in which junior doctors are trained, and they get menu-based training, sometimes referred to as "taster training", to encourage them and ensure that they get exposure to it all. Therefore, they are encouraged to work in all sorts of areas. That is much more prevalent than was previously the case. A big effort goes into making sure that that happens.

The Chairperson:

That concludes members' questions. Thank you for coming along today and spending so long with us. It was a very useful session. You are probably due in the studio shortly, are you Minister?

Mr Poots:

Not that I am aware of. I was hoping you would keep me here until after 6.30 pm. *[Laughter.]*

The Chairperson:

If you had sent us a note, we could have kept you talking. *[Laughter.]*

It is appropriate that we heard that news from you in the Committee and that we did not learn about it at second or third hand. We appreciate that. The timing worked out reasonably well, and we were able to get the announcement up front. The Committee has been given its due place. If there are any further updates during the summer, we look forward to hearing about them from you. We will not be taking a lot of time off, and if there is a pressing need for a further reconvening of the Committee, all the members here have indicated that they are prepared to meet you again. Thank you very much for giving us this time in what has been a busy day in a busy week. We look forward to hearing more about the review in September or before that if need be.