Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Health and Social Care Review: DHSSPS/HSCB Briefing

28 March 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Mark Durkan
Mr Samuel Gardiner
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

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

The Chairperson: Gentlemen, you are more than welcome. We have been seeing you a lot recently — I do not know whether that is a good thing or a bad thing. Minister, I know that you are here to give us a presentation on the health and social care (HSC) review. However, I think that it would be a wee bit remiss of me not to touch on the recent events concerning A&Es. You are well aware of that situation. Hopefully, we have come out of a bleak situation for our A&Es across the board. It is been a hard period for staff and for patients and their families. We have dealt with extremely long waiting times. I know that you made a statement about the matter last week, but I wonder whether we could get a further update on it. It would also be good if we could get an update on your meeting with the chief executives yesterday. I think that one of the key issues in this is accountability. People have been asking where the buck stops and what will happen. So, can give you us an update on where we are?

Mr Edwin Poots (The Minister of Health, Social Services and Public Safety): I am glad to do so, Madam Chairperson. I did three things yesterday that will be of interest to the Committee, and I will touch on them all, if you do not mind.

First, I met the chief executives and chairpersons. It was a scheduled meeting in any event, but the issue with A&Es was obviously very high on the priority list, as was the issue of performance against targets in where we are and where we should be. Emergency departments in the Southern Trust and the Western Trust appear to be operating reasonably well. The Northern Trust had particular problems with Antrim Area Hospital, but those have improved considerably. Compared with the others, Antrim

Area Hospital is small, and it gets hit with significant pressures in a short period of time, so the balance can tip very quickly and become a really significant problem. The Ulster Hospital had its struggles. To some extent, the situation there was better than the situation in the Royal Victoria Hospital (RVH), but it had its pressures as well.

Secondly, I wanted to refer to my visit yesterday to the Ulster Hospital. A total of 303 people went to the emergency department at the Ulster Hospital on Monday. At the equivalent time last year, there were 202. So, there has been a 50% increase. The hospital had anticipated that number moving up to around 227 or 229. So, the level of pressure on the unit is very significant, but it is coping, albeit that some people are waiting longer than we would like.

I should say that the Ulster Hospital has been doing very well in performance against quality. It participated in a scheme where it was measured against a range of other UK hospitals, and it came out in the top half of hospitals for performance against quality in seeing people against the 95th percentage quartile and in seeing people with sepsis and a whole series of other things that need to be responded to very quickly.

Again, the Royal Victoria Hospital appears to have received considerably greater numbers than had been anticipated. John, I think that you said that there are something like 70 admissions a day?

Mr John Compton (Health and Social Care Board): There are 70 inpatient admissions a week above what was anticipated.

Mr Poots: That has put considerable pressure on the hospital as a whole. So, we will be working with the improvement group to ensure that we have better flows in the hospital and appropriate discharge, both of which should help to some extent. There is certainly a lot of pressure on our emergency departments this year. Some of it was not anticipated, and that has caused some of the problem.

Thirdly, I was at an event yesterday to celebrate the Southern Trust receiving a very significant UK award for its terrific work in telemonitoring. It was also runner-up for another award. So, there are good things happening in our health service and health systems. Two of those events yesterday related to the quality of provision in the Ulster Hospital, and all the records indicate that it is achieving a very high standard of quality. In addition, the Southern Trust has received those significant awards, which are nationally recognised. However, we still have an awful lot of work to do, and that is recognised. You, as a Committee, were at the Royal, and you spoke to the staff. One of the things that concerned me was that there were 13 unfilled nursing posts over the period concerned. I was not happy about that. Eight of those posts will be filled in the very near future, but, over the winter period, particularly when you have the pressures, it is not good to depend on bank or agency nurses. You need to have close to your full complement of permanent staff so that people with the expertise can deal with problems very quickly. I intend to have a further separate meeting with the Belfast Trust chief executive and chair to further discuss those issues outside of the larger group.

The Chairperson: We will allow you to make your presentation, because some questions will probably come up on the issues with the Compton report and where it is sitting, and we might get some of the answers to those in the presentation. I will then open the session for questions.

Mr Poots: OK, thanks again for the invitation to come and talk on the progress of the Transforming Your Care (TYC) proposals. I reaffirm that we see what is presented through the review's proposals as an overdue change to our health and social care service. It is a major and significant change, and it is one that is required. It is crucial that we get it right, and I am encouraged by the broad support that the report was given by the Committee, the Assembly and, indeed, from across the sector.

At the previous meeting, I advised that the Department was assessing the proposals and how the Health and Social Care Board (HSCB) and others will take them forward. One essential aspect of the overall process is that it allows consideration of the potential implications of how proposals and the interrelationships between them can be best managed and progressed. They have given the Department and the HSCB a clear remit to progress the transformation process with vigour and energy. My specific direction will be confirmed in a letter from the permanent secretary to the HSCB setting out

the response to the 99 recommendations. The roll-out of Transforming your Care will involve major developments, with significant contributions from every part of health and social care and the Department.

Robust governance arrangements are needed to ensure effective planning, co-ordination and delivery that fully respect the formal roles of each organisation that is involved. When I met you on 1 February I advised that that was going to be a priority for me. The oversight and governance arrangements have been agreed and are being put in place in the Department and the HSCB as appropriate. They include top-level arrangements that link the specific aspects of Transforming Your Care with the other key strategies that we are pursuing, notably those on public health and equality, and with the savings plans for 2012-13 through to 2014-15. That has been described as a whole-systems plan, and it conveys the wide significance of the process that I am determined to take forward.

The arrangements also include HSCB-led management arrangements that are consistent with commissioning responsibilities across local commissioning groups (LCGs) and trusts and that are informed by a health and social care expert professional panel. Those arrangements will ensure clarity of direction for LCGs and trusts so that the development of population plans can be taken forward. The development of population plans by the end of June 2012 is one of the key milestones under TYC. The population plan process will be the focus of detailed work over the next few months and will provide a road map and direction of travel for the rest of the transformation process. Work will be taken forward in other priority areas as population plans are being developed so that those can be taken forward without delay once the population plans are in place. That will include, for example, work on the development of integrated care partnerships.

I have asked that early work be done on some integrated care initiatives across Northern Ireland so that a significant new emphasis can be given to primary and secondary care working together on patient-focused, high-quality care and to the further application of the integration of health and social care. My officials and officers from HSCB met their counterparts from the Department of Health in Dublin on 22 February to discuss mutual areas of interest. They will be looking at the scope for areas of joint working or sharing of best practice. They will meet again over the next few days.

As I highlighted when we met in February, the implementation of the review cannot be carried out in isolation. Various aspects of work will form part of the whole-systems plan. Those include, for example, the work on the commissioning plan. At your meeting on 1 February, my officials briefed you on the draft commissioning plan direction and indicators of performance directions. I wrote to you on 27 February to address issues that the Committee raised about the directions. Those were subsequently issued to the HSCB on 29 February.

Work has also started on the development of trust savings plans for 2012-13. Those plans are still being developed and are in draft form at this stage. Approval has not been given either by trust boards, the HSCB, LCGs or me. They need to take account of the commissioning plan when it is developed. My focus is to ensure that the quality of patient and client care is protected and improved through this reform process. Services need to match best practice, and there will be shifts from the acute sector to providing more services in the community and primary care sectors.
The need for effective communication across all aspects of HSC is critical to ensure that there is a thorough understanding of the practical implications of the proposals across all relevant and key areas. In that respect, a series of workshops on areas of care detail and TYC are being arranged for relevant departmental, HSCB and Public Health Agency (PHA) senior staff. The workshops will help to ensure a shared understanding of the substance of the proposals and their practical implications at the coalface. Of course, work will continue to develop in other areas, which will ultimately contribute to the overall transformation programme.

There is an opportunity for the greater use of technologies to support the delivery of services, which we see at present with the use of telemonitoring for patients with long-term conditions. There is an opportunity to build on that and to exploit other opportunities where technology can support the delivery of effective health and care services. In December, I launched the Telemonitoring NI service, which should benefit 20,000 people over the next six years. In visits to Finland and the United States, I saw how the development and use of technology can support effective healthcare in the future, as well as

the potential benefits to the economy from research and development and innovation in health and life sciences. I believe that Northern Ireland can and should be at the forefront of such developments.

Change is never straightforward, and fundamental changes to the way that we deliver services are required. The retraining of some staff and the redesigning and reconfiguring of services will also be required, and that will not be without pain. It will take time for the new model to be fully implemented — the review envisaged a five-year timescale for that. However, it would be a mistake for anyone in the system to think that they have four or five years before there is fundamental change. Much of the change must happen very early, and I am pleased that progress is being made in line with the timescales envisaged in the report. It will be important for the public to see and feel change in the coming months as opposed to years. If our health service does not feel considerably different by the end of this year, we will have failed.

The Chairperson: Thank you, Minister. I have a number of questions to ask, but we also have the Allied Health Professions representatives in later.

Mr Poots: I bumped into them earlier.

The Chairperson: I hope that they were nice to you.

Mr Poots: I am usually nice to them, because I think that they are going to provide a both major solution and early intervention.

The Chairperson: That is good, because I am going to ask a question on that, but, in general, I think that —

Mr Poots: Since you raised the subject, I will inform the Committee of something, if you do not mind. I discovered recently that podiatrists are carrying out foot surgery everywhere in the UK, apart from in Northern Ireland, and many of them travel from here to England and so forth to maintain their skills base. So, I expect a paper any time, Andrew, —

The Chairperson: I think that you have a spy in my office.

Mr Poots: — on what we can do.

The Chairperson: Well, that is one of my questions answered. Thanks very much. *[Laughter.]*

Mr Poots: It struck me that orthopaedics waiting lists is one of the areas in which we perform poorest. We have people who can take some of the burden away from orthopaedic surgeons, but we are not using them.

The Chairperson: Absolutely, and a lot of this is about taking a common-sense approach, so I appreciate your handle on that. I do not like to say this as though the man is not here, because when you mention someone's surname it sounds as though they are not here, but Compton was viewed as the way forward in health. I am talking about you, John.

We need to see changes, especially given the bleak couple of weeks that we have come out of. We, as politicians, and you, as the Department, have come out of it, but patients have suffered, and we are all trying to make a difference for patients and their families. It would help to have an idea of when the commissioning plan will be published — you mentioned April 2012 to March 2013 — and when the Committee will have sight of it, because we have a duty to scrutinise what is happening.

It goes back to the point that I made to John a number of weeks ago. We are now in a devolved institution, and, if it is done right, the Compton review will mean that John will be talking himself out of a job.

The other point that should be made concerns the allied health professionals (AHPs). A lot of good work is being done. The information is that the University of Ulster trained 11 professionals to provide

supplementary prescribing for physiotherapy patients, but still, none of them is doing it. Bringing more services back into the community setting seems to be a way of taking pressures off hospital settings without duplicating provision. If I have to go for physiotherapy and need a certain medicine, I have to go to my doctor. So, if we have people trained to do such work, why are they not doing it?

Can you give us an idea of your views about some of the new health centres that are being opened? What are we hoping to do with those centres, and what will be in them? Are we talking about making more services such as those available to take people away from acute settings?

Mr Poots: OK. There are number of issues there. I will leave the commissioning plan until last, because I will bring John in on that.

You talked about making better use of resources, and you mentioned the allied health professionals. I attended a conference of specialist nurses today at the King's Hall, and I listened to a specialist nurse, who deals with urology, from the Western Trust. She talked about nurses prescribing. Nurses already carry out a lot of work that doctors would have done previously, and they spend considerably less time mopping up sick and so forth. That is not what they were trained to do; they were trained to care for people, and that is right. We need to use their skills properly. So, I encourage that type of activity, and where someone has a skill to safely deliver a service, we should use them to do it. That then frees up the person who has the skills to do the other things to get on with their work. That is why I was quite taken with the podiatrists carrying out foot operations, for instance. So, in all these things, we need to follow that example.

The point that I picked up from you, Chairperson, is that we seem to be very slow about doing that. These things are practical, sensible and rational, so why are we not getting on with them? Perhaps we can identify for the Committee over the next few weeks — maybe for when you get back — the sorts of things that we can be doing and a time frame for getting them done as opposed to just saying, "It has been happening somewhere else for two years, so maybe we should be looking at it now.". We do not need to be at the end of such a process all the time; we can be in there at the start.

There were three things that I wanted to respond to, but I have forgotten —

The Chairperson: The health centres.

Mr Poots: Yes, the health centres. The centres in Banbridge and Ballymena have got the go-ahead, and the work of removing old buildings and so forth will start immediately. The services that are on offer in the Ballymena health centre are really good. It brings virtually everything under one roof in that town, and, although three GP practices will not be involved, seven practices will. Virtually everything else will be provided for: mental health services and community dentistry will come back from Antrim Area Hospital and will be provided for in Ballymena. Allied health professionals will be in there, and district nurses will also be based there. They will be using shared office space in that facility. X-rays will be done there, so there will be diagnostic ability on the site. I believe that the centre will have a transformational impact on care in that area.

I may be getting a paper on two other areas — Lisburn and Newry — that may involve using third-party development to achieve. We are looking at bigger centres that can cover as wide an area as the centre in Ballymena and that can provide the same type of care. We think that we can deliver much more in the primary care sector if GPs are under the same roof as allied health professionals and specialist nurses. With all the community infrastructure and the diagnostic capabilities on site, it is our view that we will be much more successful with early intervention and will avoid hospital admissions. I said that I am getting a paper on Lisburn and Newry, but I do not want it to stop there. I want to identify how we can deliver more of those facilities, because they play a key and fundamental role in changing the pattern of care.

Last year, we had a real problem, because we did not have a commissioning plan until far too late in the day. We should have a commissioning plan at the start of the year, and I think that we are fairly close to having one. John can maybe confirm that.

Mr Compton: Yes, I can confirm that. The draft plan will come through the April board meeting and will then go to the Minister.

The Chairperson: Can we get sight of it?

Mr Compton: Yes, I am sure that that would be possible. There is no difficulty there at all.

The Chairperson: Are you hoping that, when the draft plan is implemented, Compton is done?

Mr Compton: It is a slice off; these things are joined up. Transforming Your Care is aimed at a longer period of time, and the commissioning plan is, if you like, an entry point into that and into its commencement.

The Chairperson: You are right, Minister, to try to get that stuff. We have a response from you on osteoporosis and fracture services. We are going to write back to you about it, but, now that you are here, I will ask about it. Something like 20 GPs surgeries do not offer those services. Some GPs are signing up and doing good work, but 20 are not, and that is having an impact. We are now back down the road where people do not know whether their GP provides the service, and we are then into a postcode lottery. If we are trying to get people out of the surgical end or the acute sector, why have 20 GP surgeries decided to opt out? What can we do?

Mr Poots: Ask the man who commissions the GPs' service to answer that.

Mr Compton: I think that you may be talking about enhanced services. There are core services for general practice. General practitioners do not have the option to opt in or out of those. Then there are enhanced services in which people have the opportunity to either participate or not. However, a key issue for us in Transforming Your Care is the integrated care partnerships, which involve GPs working together as federations. The objective is to make sure that those sorts of services are available to all citizens in given populations. That is at the very core of what we are about and what we see as a fundamental issue.

I will expand on that a little bit. Issues such as prescribing and the greater engagement of other professional groups are very much not GP-orientated or GP-dominated issues; they are a professional grouping arrangement. The idea is clearly to get all those individuals working closely and jointly so that we get those services. We are constrained from time to time in what we can do in general practice because of national contracts and the way in which they are structured. One of the attractions of moving towards integrated care partnerships is to see whether we can revise some of the arrangements by which we are able to acquire services locally. There is much work to be done to get that through a proper governance system as such, but that is one of the attractions that is really quite important.

The Chairperson: I appreciate that, John, and I appreciate the difficulties that exist with a lot of the contracts. However, 334 GPs offer the service for osteoporosis, and 20 do not. We will write to ask for more detail on that, and you can have sight of that information. For example, in the South Eastern Trust area, 51 practices offer the service and three do not. So, your explanation about GP contracts does not seem right when, in one area, 51 are offering it and three are not.

Mr Compton: I am very happy to look at that information and to get back to you specifically on the detail of it.

The Chairperson: OK. I will open the session up to other members, and I will come in at the end on some issues.

Mr McCarthy: You mentioned what I want to ask about, which is the importance of engaging with the allied health professionals and their expertise during the implementation of the review and in the future at a strategic and operational level. Can you advise the Committee about that?

Mr Compton: I do not have any difficulty at all with that. I and the group made reasonable efforts to talk to a variety of professional groups during the review process. If you look at Transforming Your Care, you will see that it acknowledges that and indicates that we see a fairly vital role for all sorts of professional groups working in the local community. It is common sense to use the skills and expertise that you have to make sure that services are better placed. I have no issue there at all; they are going to be part and parcel of where we are in the future.

Mr McCarthy: Will that continue?

Mr Compton: Absolutely; yes.

Mr Poots: I will be actively encouraging trusts to employ more allied health professionals, because I see that people such as podiatrists can help to reduce falls considerably. I believe that the proper use of physiotherapists in conjunction with general practitioners will lead to fewer people being admitted to hospital with chest infections and so forth. I regard that as an investment that will deliver a better service, as well as savings, to the system. I am very clear about where I stand on the issue.

Mr McCarthy: I am grateful to hear that. I get the feeling that there may have been a case of them being left out at times, but it is very useful to hear you say that you are going to engage with them right throughout the process.

Mr Poots: I think that they themselves have an issue, because they do not have a representative who works in the Department. We have a Chief Nursing Officer and a Chief Medical Officer, but we do not have someone who represents that sector. Perhaps Andrew could expand on that.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): We do not have representatives of allied health professionals in the Department, and it is a point of concern about which I have had many discussions with the groups over the years. It is an issue on which we need the right input to policy from the groups of professionals, because many aspects of it are highly relevant. I have also repeatedly encouraged that proper status and recognition of the function be given at trust level. There is a senior AHP in the Public Health Agency as well. Part of the role is to ensure that the professional plays his part, and we can draw on the benefits that John and the Minister mentioned.

The Chairperson: I know Andrew, but with due respect, and this is a point the Minister made, you have had the discussions over the years. We need to make changes, and we need to make them as quickly as possible. I think that it is important that we look at this instead of having discussions "over the years" on a lot of matters.

Dr McCormick: I am saying that there is always a dialogue. A process goes on, and there is a place where we are receiving the expert input and advice. Changes need to be made to ensure that those functions are fulfilling their full potential in the service context and that there is every support for that at departmental level.

The Chairperson: I will come back to self-referral in a second.

Mr Gardiner: I record my appreciation to the Minister, because this morning he visited Lurgan, which is in my constituency. That visit was to those who are involved in home care in particular. It is amazing how that is turning round in itself. The carers and professionals who were there from the hospital are taking on board more the concerns and thoughts of the people they are caring for. It was very encouraging to see some people there and the way that they turned out. They are being treated as real people and not merely as old people sitting in chairs. I encourage more of that, Minister, if it is humanly possible.

Later on, I had the opportunity to go over to Tesco, because I got an invitation to go. A 'Love your Lungs' initiative was taking place there. It was amazing to see the people queuing for that. You had to inhale into an inhaler, and a recording was made. It could tell you whether your lungs were clear, whether you were short of breath, or whether you were a smoker and had to stop. I was very

encouraged by that. The more we get into the public and get the public involved the fewer admissions into the hospitals there might be.

The Chairperson: I thought you were going to say, "Love your Dunnes". Do you want to respond to that, Minister, because I think that Sammy is making a valid point? The further we can get into the communities the bigger the difference we can make.

Mr Poots: Usually, Sam, when I am at the Jethro Centre, it is midnight or shortly afterwards, when I am collecting the young ones. It is a good facility and does great work in Lurgan.

As to working with organisations such as supermarkets, it makes sense to go where the people are. People will not always come to a doctor's surgery, particularly the menfolk. We should go to where the menfolk go, because they do not go to doctors very willingly. If we go where it is convenient for them to have a health check, we can make a difference. If we can detect the early warning signs, we can tell them, "You have some difficulties here, but you can arrest those by doing x, y and z." A lot of people will listen then, so it is a valid point.

Mr Gardiner: When I had my health check done, I went back to the office, collected my staff and brought them over to make sure that they had theirs done, too.

Mr Poots: It is something to work on with the PHA.

Mr Dunne: It is good to see the Minister and the panel today. It is also good to see the Minister taking the issues seriously and getting out to see what is happening on the ground. We appreciate that. We visited the Royal Victoria Hospital A&E on Monday and were very impressed with the staff's commitment and professionalism. We were treated with courtesy and shown everything at first hand and in an open manner.

I was talking to one of the doctors, who told me that the bottom line is the trolley waits that result from the overload in A&E. However, the follow-on from that is the processes themselves in the hospital. How can we make progress? Will the Compton report, as we call it, when implemented, go a long way to resolving the issues?

I also appreciate the fact that the Minister visited the Ulster Hospital, which covers my constituency of North Down. We have been deprived of hospitals there for many years, but I will not go over all that. Obviously, the Ulster Hospital is key to the health of my constituents. However, from the figures that we saw and that have been mentioned today, 303 people a day went through the A&E at the Ulster Hospital. That is a significant number of people. The average for the Royal is around 260 a day, if I have the figures right. That is a serious number of people, and it takes a lot of resources to manage those people through the system. Those numbers serve as another warning that we need to be proactive, rather than reactive, to situations. We appreciate that the Compton report is available. Its implementation will now, we trust, make a difference. We would like some assurance that that will be the case.

Mr Poots: Interestingly enough, when we were at the Ulster Hospital yesterday, consultants indicated that they have a greater number of people coming to them with more significant needs because of the effectiveness of the minor injuries units in Ards and Bangor. Those units screen out a lot people, and a lot of people use those units.

Mr Dunne: I am aware of that. Some 1,000 people a month use them.

Mr Poots: I think that the figure is around 20,000 a year. I am not sure whether that is 20,000 people using each unit in a year or whether it is 20,000 in total, but the units certainly screen a lot of people away from the Ulster Hospital. That leaves the Ulster Hospital with a higher number of category 1, 2 and 3 patients to deal with, perhaps in place of other hospitals dealing with them. That is important.

John, do you want to respond on 'Transforming Your Care'?

Mr Compton: The first thing to say on the management of hospitals is that part of the escalation and work that we are doing is on the basis of evidence. We will be working very closely with our trusts on what we know works: discharges before noon; admission on the day of surgery; consultant vetting for admission; ward-round regularity; and seven-day as opposed to five-day working. We know what the evidence is. There is a very concerted effort to look at that sort of information and at the internal performance of each organisation. That is important.

At the heart of TYC, changing the pattern and provision of our hospital services is dependent on that industry and energy working very successfully and well. That is right, and I am sure that the staff expressed to you the view that they do their job very well in assessing the individuals, and it is time to get the individual from their part of the hospital to where that individual should remain in the hospital. That is done by the close management of those systems and processes. We are looking at that currently. Obviously, the purpose of TYC is to recognise that the system has served us very well but it cannot serve us into the future. The service into the future needs to be changed, and we need to do that. We need to do the tomorrow thing but also pay attention to today. There is no point in saying that circumstances will get better if people think that the experience that they are having today is not good. We have to do the two things at the same time and push in the one direction. That is where we are going with TYC, and I am very optimistic.

Dr McCormick: To reinforce what John said, I think that there is a lot that can be done in the present day. There is a significant evolutionary change arising from the report, and so on, but, as John said, applying evidence-based good practice in the here and now should make it possible, and the commitment is to make it possible to secure the removal of 12-hour waits in a short number of months. The Minister said that that is the objective, and the team is clear that we need to apply all the good practices that we know about. As the Minister said last week, it is about a series of small steps. It is about checking that those are being applied and about maintaining the involvement of the whole system. This is not just for A&E departments or the directors of operations in the trusts. The whole leadership team across the service needs to be focused on this. We cannot allow financial considerations to dominate. We have to ensure that the focus is on providing high-quality services that are safe and give a good patient experience. There are a lot of straightforward techniques in the hospitals and right into community and social care that contribute to that. We know about those. John and I are in correspondence to establish an up-to-date list of all the right things to do. We will then assess whether the techniques are being applied continually, faithfully and effectively to make it work.

The Chairperson: I have raised the issue about other parts of the hospital supporting A&E. If a directive is sent around tomorrow that states that senior clinicians and others need to work beyond 6.00 pm or 7.00 pm and at weekends, where do those negotiations take place? Here or in England?

Mr Compton: It would not be a negotiation necessarily about their individual contract. It would be about how many people are needed. At the end of the day, there are 24 hours in a day, so we have to have a certain number of people there.

The Chairperson: Will that be easy to do? Will there be a blockage, because it might have to be negotiated in England?

Mr Compton: One of the key issues for TYC was to understand the workforce implications as we go forward. If we are trying to work on a seven-day system, we know that we can work on a seven-day system in a smaller number of facilities. That is a matter of fact.

The Chairperson: But it will not be a problem or a long —

Dr McCormick: We do not need to go to England to negotiate anything. All the necessary and appropriate interventions are in a devolved context. It is all possible, and nothing fundamental needs to change in the HR dimension. It is much more about application, good management of rotas, and good involvement in leadership from senior doctors and nurses. It is all about —

The Chairperson: Can band 5 nurses be changed as well? You were talking about band 5 nurses being able to discharge patients.

Mr Compton: Clearly, any banding of a given nurse or a given nursing role is inextricably linked to their responsibilities. If people's responsibilities fundamentally change to be of a different nature —

The Chairperson: That can be done sooner rather than later?

Mr Compton: It is a matter of local interpretation, not something that requires national debate.

The Chairperson: We are not going to be at this for years?

Mr Compton: I hope not.

The Chairperson: John, we are not going to be at this for years.

Mr Compton: No.

The Chairperson: The Minister made a statement last week —

Mr Compton: No, sorry, but I was responding particularly to the band 5 situation, because those nurses have a particular and individual set of circumstances. Their situation can be dealt with in that way.

Mr Poots: We are not going to be at it for years.

The Chairperson: Good.

Mr Poots: There is no hoping about it: we are not going to be at it for years.

Mr Dunne: At what stage are we with the implementation of the whole plan? Has the programme board been set up?

Mr Compton: Yes, the governance arrangements have been agreed, so the Department has established its arrangements, as has the programme board . We had our first board meeting yesterday. Each of the local population groups have been meeting LCGs and the trusts on the structure of the population plan. We issued advice and guidance about consistency in population plans so that one area looks reasonably consistent with another.

The Department of Finance and Personnel (DFP) is considering a business support case for the plan and design stages to enable us to get the population plans completed by the end of June. We are pretty much on target, and anyone in the room yesterday hearing the issues being discussed in each population area will have realised that a tremendous amount of local energy is going into the issues that are being reflected on for the likely content of the population plans.

We are also making energetic moves on the integrated care partnerships and planning for those to be running live from as close as we can to the beginning of next month. What will they will be doing? In particular, we are looking at them supporting nursing homes as a given. Another issue is the management of diabetes as a long-term condition, because, as far as all that is concerned, it has to be done in steps and stones.

There is a fair bit of energy, and we are confident that we will have population plans by mid-June.

Dr McCormick: The approach is not exactly as on page 130 of the report. It was designed for arrangements that recognise the different responsibilities that apply and that ensure especially that the strands related to commissioning are also linked to work that the Department is leading on public health. John and I are involved in further work on infrastructure and on the significance of health and care centres as a contribution to change. All the strands are being brought together into the financial plans. In fact, we have to be in financial balance. That is part of the job.

Therefore, we are applying commitment and energy, as the Minister is requiring of us. We are clear about the urgency and determination to make a significant difference as quickly as possible. That requires some order. There are significant policy issues in the middle of all this that the Department needs to look at. However, everyone is pulling together.

We have effective arrangements for engagement. We will use the partnership forum to ensure that staff side is fully engaged and briefed and there is opportunity to have significant policy and operational discussion with trade unions. Their involvement is not narrowed to HR issues but, properly, they are able to discuss with John, me and others to influence the way in which this is applied. The arrangements are all in place. The timetables are demanding because we have to ensure that there is a significance difference during the course of this year.

Mr Dunne: Would it be fair to say that you are satisfied with progress made to date?

Mr Compton: Yes.

Mr Dunne: Is the clinical forum set up?

Mr Compton: We are making direct approaches. It will be called "expert panel". "Clinical forum" perhaps carries the connotation that it involves only medical personnel. The expert panel will allow other personnel to be there. For example, there was some discussion earlier about allied health professions, and such. We are in the process of making direct approaches to individuals to be part of the panel.

Just to remind and restate: it is not a veto group. It is there to be a support group and to give advice and guidance. It is not there to block and veto. It does not have that role or responsibility. It will be a transitional grouping, in that we will add to the expert panel if a specific requirement means that we need to. The panel will advise us on where we should go for other advice and guidance if that is required.

Mr Dunne: Do you reckon that we will see progress with implementation on the ground by September?

Mr Compton: By the end of June, there should be five population plans, which will signal the steps and stones that are beginning to happen in the context of each population area during this year. I expect there to be one or two fairly significant changes in each population area, and those changes will be in the process of some degree of implementation during this year. If you take that right across the system, it suggests that one would expect to see significant change from where we are now.

Mr Dunne: Good. Thanks very much.

Mr Durkan: I welcome the Minister, John and Andrew here today. I like the confidence with which the Minister stated that change will be implemented, and implemented soon. Following on from Gordon's point, I noted that John touched on the importance of the involvement of patient groups in mapping out future service delivery. Where exactly do those groups tie into that process? This morning, I met the Long Term Conditions Alliance (LCTA). It has bought into and subscribed to your view of future care, but it wants to ensure that nothing is lost in transformation.

Mr Compton: There are two levels to that. The first level is when the population plans are being developed, the expectation is that people will talk to local groups. This is not being done without ongoing debate and discussion with local community interest groups, long-term condition groups, or whatever.

We anticipate that the expert panel will also give us a route into being able to talk to more nationally or provincially organised groups, so there will be a route there as well. I hope that it is covered at the top and at the bottom and that, when they come through, the population plans will at least have touched on those sorts of areas. Not everybody will agree with everything, but the objective is to make sure that there is some inclusivity.

Mr Durkan: In opening, the Chairperson said:

"we have come out of a bleak situation in our A&Es",

but I fear that we have only come out of this bleak situation in A&E. To move on, we need assurances on what actions are being taken to avoid such incidents occurring in future. You said, Minister, that Antrim Area Hospital is operating well, but the balance could quite easily be tipped. There is a fine line between operating well and chaos.

The Chairperson was chatting about the band 5 nurses. We met the Royal College of Nursing (RCN) on Monday. The RCN expressed serious concerns around the disproportionate number of band 5 nurses and said that it was more of a resource issue than a skills one. What are your views on that? Is there a way of addressing that? If so, are people's skills or responsibilities going to be looked at again so soon after Agenda for Change?

Mr Poots: There has been a traditional issue around the banding of nurses. Nurses in England are probably operating on higher bands. We need to ensure that if people are given responsibilities, they need to be given the band that goes with them. If we do not value the work that is being offered, we do not maximise the outputs from individuals. However, it is very difficult to ask individuals to take on very significant responsibilities and then tell them that they are being kept on the lowest pay band. We need to ensure that people are in the appropriate band for the responsibilities that they are given.

You asked about A&Es. Mary Hinds, who carried out the work in Antrim Hospital, has agreed to head up the improvement action group. We will resolve that issue at Antrim Hospital. The capital works are now under way, and, in the first instance, the accident and emergency department will be of a scale that can cope with the numbers attending, and we will actually have a bit of capacity.

Moreover, we are increasing the bed space in Antrim Hospital, because that is a big problem. An additional 40 permanent nurses have been recruited, and the hospital is in the process of seeking to recruit additional consultants.
I think that the Antrim Hospital problem will, in due course, be one that has considerably less chance of becoming a crisis situation. However, it will be some time before we get to that point. We will need to manage and monitor the situation carefully in the intervening period. It might be useful were John to bring you up to speed with where we are on the improvement action group, which will be working closely on A&E issues over the next number of months.

Mr Durkan: Even beyond issues with consultants.

Mr Compton: We have talked to all the providing organisations. We now have a central team, which will be led by Mary, supported by a range of staff from the board and the PHA. The team will liaise directly with each of the organisations and with senior staff in each of those organisations. We will be using the evidence base as, if you like, the vehicle by which we understand the particular issues that exist. As I mentioned earlier, those include issues such as discharges before noon, which we know has a material effect on how well a hospital can function later in the day, when most admissions tend to occur, and arrival for surgery on the day of surgery as opposed to the day before. There is a range of evidence bases that we will be following with each of the organisations. We will be working with them but will expect them to achieve a certain performance. We know that that will allow them to pull the patient through the hospital correctly. When it comes to discharge, there will be different arrangements for people with complex discharges and people with less complex discharges, to make sure that that happens.

One thing that everybody learned in Antrim Hospital — I know that Mary would say this — is that every 15 minutes matters. Sometimes, people may think it not such a problem if, for example, their pharmaceuticals come 10 minutes later than was anticipated, but it is a problem if the ambulance to take the patient home left 10 minutes ago and the next ambulance is not leaving the hospital for four hours. That is the concept: every 15 minutes really works in the process. We will be working very closely with the organisations to ensure that that is happening.

I think that none of the organisations is content with where things are. No one is content with where everything is. Everyone is very sensitive to the fact that one or two individuals have been in very difficult circumstances. No one in the system wants that to be the case. People want to be in a different place altogether. I am very optimistic that that energy will result in material change, particularly to the long waits. There are other things that we need to pay attention to, but, first up, long waits are the issue.

Mr Durkan: The vast majority of healthcare professionals whom I speak to are certainly not afraid of change and would welcome it. However, they are fed up with talk of it. My main objection to 'Transforming Your Care' is its lack of detail around health servants. I have raised questions about those nurses at band 5. We talked about looking at regrading people. If, as I suspect, the disproportionate number of band 5s that we have is resource-driven, would upgrading nurses ultimately lead to a reduction in numbers? At this time, that is the last thing that we want to be looking at.

Mr Poots: There are a lot of pressures, without doubt. However, if that takes workload away from more expensive staff, such as clinicians, it does not necessarily have to be a resource issue. All that has to be thought through. It is a fact of life that nurses do take on far greater responsibilities than they did previously. For example, a few years ago, a nurse would not have been giving chemotherapy. That would have been done by a doctor. We are now looking at nurses prescribing. Clinicians themselves would say that the nurses in, for example, the diabetes clinics are the glue that holds everything together. If there are people out there delivering tangible benefits for the system, it does not necessarily follow that investing more money in them will cost more. We need to look at that closely. It could end up that people are better paid but are delivering savings at the same time.

Mr Durkan: Therefore, newspaper headlines about 500 nursing posts being lost are inaccurate?

Mr Poots: That is a newspaper headline. I have not got the reports yet, but I suspect that that will not happen on my watch.

Mr Durkan: Where is Jim today?

The Chairperson: John, I do not think that you are meant to like this. I agree with you that no one likes the fact that one or two people have found themselves in difficult situations, but we are hearing about one or two people every day.

Mr Compton: I do not mean one or two in that situation.

The Chairperson: It can be one or two in the Royal, then in Antrim and then in the Ulster. We need to focus on and target the issue. I am sure that everyone here, including you and people in the Public Gallery, will know that people are genuinely more afraid to go to some of our A&Es. That is not a reflection on the staff. We need to send out the message that our A&E departments are safe because senior management and the Minister are looking at the situation and holding people to account. If people are failing, we need to look at that, because what we are doing is failing our community.

Mr Compton: I have no difficulty with that at all. None whatsoever.

Mr Poots: A clear difference needs to be identified between a bad experience perhaps involving a person who has been waiting a long time to receive care and a bad experience relating to quality. It has not really been picked up in the media, but we are driving upwards the results that we are getting on strokes, heart attacks, trauma and sepsis, for example. In all those areas, we are getting better results than ever, and that needs to be recognised. That is the real test, and that is what an emergency department is about, first and foremost. However, if an elderly person comes in with a respiratory problem and needs to be admitted to the hospital but has to wait for a day and a half on a trolley before getting into the hospital, that is a bad experience.

The other issue concerns first priority, because those are very often emergency situations, which are life and death situations. The service that people are getting in those life and death situations is absolutely superb. We need to ensure that, throughout the system, the service is absolutely superb.

Ms Brown: Thank you, Minister, John and Andrew for your time. As Mark did, I want to touch on the A&E update that you gave at the start. I was going to focus particularly on Antrim Hospital. You addressed a lot of what I was going to ask in answer to Mark.

Mr Durkan: Sorry.

Ms Brown: You mentioned the 50% rise in the number of service users at Dundonald. Is there any indication of the reasons for that, or have you an idea of why there is such a huge rise? You talked about the improvements in treatment and how more successful they are. People are living longer, and we are able to treat symptoms more successfully. I suppose that you become a victim of your own success, in that people live longer with more complications. They need more care, and it goes on and on. That is good and to be welcomed.

I am also aware that the media can be very one-sided. Of course, there are stories that none of us wants to hear, but, I am sure that, to go with every one of those stories, there are dozens of good reports that come back from hospitals, especially about the treatment and quality of care that people receive there. We have to be mindful of that.

Last week, we visited the Northern Ireland Ambulance Service (NIAS) and were told about what it has put to the Compton review, including the idea of using a non-emergency 111 number. A decision has to be made on whether that will be brought in, but, to our ears, it sounded fantastic. At this time of day, who would you ring if you needed medical assistance? You would not get an appointment with your doctor, and you would probably not even get a phone call with your doctor. The out-of-hours service would not have kicked in, so where would you go in between times? If that kind of service is being considered, how long will it be before those sorts of major decisions can be made and before we can make the best of what we have in the health service, the community nurses and all the services that are out there? It might just need a bit of improved technology. How quickly can those types of improvements be brought in?

Mr Poots: Hopefully, the 303 people who were at the Ulster Hospital will not represent the general run. That just happened to be the situation on Monday. It moved up ahead of the anticipated number after the closure at the City Hospital. There is a sneaking suspicion that, given all the coverage of the Royal over the past couple of weeks, there has been a shift in the public, who are saying, "Well, I'm not going down there to wait all that time; I'll go over to this hospital instead." Hopefully, that will level out again. As I indicated, the hospital is coping, but that creates a little pressure. So, I hope that that will level off over the next number of weeks.

Mr Compton: The ambulance side of the house is very supportive of that, because, in a way, the ambulance is a conduit that will make the process work. We have signalled very strongly that we want to see ambulance services support some of the changes. That will be quite important. That includes things like the 111-type number. So, all that is being looked at very closely. As soon as we can practically move to those things, we will do so. I am sure that you were told that one of the things that is being considered is whether patients can be redirected. At the core of Transforming Your Care is the idea that we have become defaulted to hospital for everything when, in fact, a substantial number of people who need help and support would be better going to a more appropriate location. We have a traditional pattern of how that occurs. So, all those things are being looked at very actively.

Ms Brown: That is great. I think that around 70% of people present themselves to A&E. I take it that you would have to have a big media campaign to bring in the changes?

Mr Compton: In Transforming Your Care we signalled that emergency activity has four or five levels: regional trauma; blue light, which is what everybody most commonly thinks of about an emergency department; urgent care, where you see a doctor; minor injuries; and out-of-hours services. The challenge is to get the right proportion of all those services for our population. When we hear from population plans how best they want to deliver that and where they want to deliver it, we will expect to see and consider those key driving issues. Ultimately, it will be for the Minister to consider and approve.

Mr Brady: Thanks very much for the presentation. Just think, John, if it all goes well, they will name a new hospital after you.

Mr Compton: I have been called many things. *[Laughter.]*

The Chairperson: Oh, you have, John.

Mr Brady: Look on the bright side. I am going to be unashamedly parochial, because —

Mr Dunne: No.

Ms P Bradley: Ah no, Mickey.

Mr McCallister: It is not the Mickey Brady Hospital in Newry. *[Laughter.]*

Mr Brady: Not yet, John.

Mr Poots: Is that the Mickey Mouse hospital?

Mr Brady: Minister, you mentioned the integrated centre in Newry. We have a health village there, where GPs are on site but work independently of the practices. We also have the like of the community occupational therapy (OT) service, which works very well. You talked about allied health professionals and diagnostic facilities and all, so you envisage all that going on to one site.

Mr Poots: I envisage a press release in the 'Newry Democrat', but nonetheless —

Mr Brady: It will probably be in the 'Newry Reporter'; the 'Newry Democrat' does not take a lot of our stuff. *[Laughter.]* I just thought that I would mention that.

Mr Poots: I envisage the full range of services that you would want to see in a primary community care centre being under the one roof. We need GPs to support us in this. From a health perspective, it is absolutely and completely logical that they provide the services under one roof.

Mr Brady: Might I assume that it will be a new roof?

Mr Poots: A new roof, yes.

It is not always in their best interests financially, because a lot of GPs have invested in new properties and so forth over the period. Obviously, with the slump in property prices, they will not receive the value that they would like to. That can be a bit of a challenge. I am not sure what the situation is in Newry, for example, but it is less of a challenge in Lisburn, because most of them are currently in Lisburn Health Centre and will be glad to get out of it.

Mr Brady: I have two more points to make. You mentioned meeting officials in Dublin, and you said that that will happen again. Your statements so far indicate that you have been quite pragmatic in your approach to cross-border services. Do you envisage an increase in those services? Obviously, it makes sense if it will generate more income for the health service.

Mr Poots: I have always indicated that I am an interested in healthcare and do not really see this as a political issue. I have also indicated that it could help to sustain facilities for our population if others contribute to the existing services. I have also made it very clear to my officials that we need to get full reimbursement. Taxpayers here cannot be subsidising services for others. There is an issue in border areas with people who have to pay for GP services skipping across the border to use our A&Es as a service. We need to ensure that we get full reimbursement for the service that is provided, and I expect my officials to negotiate that.

Mr Brady: I wonder whether you noticed that I mentioned Daisy Hill Hospital, and I will ask John the next question. I presume that the population plans will ultimately decide the number of hospitals. Will it be based just on numbers, or will it factor in certain areas that have larger numbers or particular health problems? For instance, my constituency has one of the highest rates of MS in the world. Other areas have particular health problems and need specialist care, such as neurological services and that kind of thing. Will it be based purely on numbers, or will it factor in particular needs in particular areas?

Mr Compton: No, it should not be based exclusively on numbers. Numbers are important, but what the numbers tell you is also important. If there are particular issues and themes in particular geographies, it would be very disappointing if the population plans did not reflect or signal that.

Mr Brady: So, there will be a breakdown.

Mr Compton: The expectation is that population plans will reflect the population's needs. To follow your example, if there is a particular MS issue, one would expect to see some sort of commentary about that and how that population might be best served.

Mr Poots: Safety is the key issue. It is about ensuring that we provide a safe and quality service. The difficulty with some of the smaller populations is that you do not have all the key personnel available to provide the service in that safe and effective way. All the information indicates that you are better to travel a bit further to get a service than to use some of the smaller local services. A lot of work has been done in Scotland on that. I suspect that people do not really want to hear that, but, medically, that is what drives a lot of this.

Ms P Bradley: I thank the Minister. I apologise for being late: I was at another Committee meeting before I came here.

Mr Poots: You were not as late as John.

Ms P Bradley: That is true.

Mr McCallister: Do not worry; I will apologise, too. *[Laughter.]*

Ms P Bradley: I want to go back to a couple of things. The first is to do with discharging people from hospital. I have been there. We get criticised day and daily about the lack of joined-up government here. From my experience of working in an acute hospital, I know that there is not a lot of joined-up thinking in that sometimes. That is not the fault of any of the disciplines, because there is good communication there. It is the system's fault. I know from a social work perspective that, for a patient to be discharged to a nursing or residential home, 35 or 39 pages have to be faxed to that home before they can go. That is just the social work side, never mind the allied health professionals or the pharmacy side. I know of many occasions when I would have been taking medication on my way home from work, because it was not ready in time when the ambulance arrived and the crew needed to get going to go on to their next job —

Mr Poots: You were bringing it as opposed to taking it.

The Chairperson: I am glad you said that, because I had visions of her taking medicines home.

Ms P Bradley: Anyone who works in the health service, and we have all said it here many times, goes over and above the call of duty. That is why they are in the caring profession. Many patients are discharged and told that they can go at 9.30 am but are waiting on their international normalised ratio (INR) tests coming back at 4.00 pm, so they cannot leave until then. The doctor's discharge letter cannot be written until then, which has a knock-on for pharmacy, and everything else gets put off. It could be 10.00 pm before they are —

Mr Poots: They are sitting beside a bed that somebody else should be lying on.

Ms P Bradley: Yes, that is blocking our A&E system. So, it is not the staff or how they do things; it is the system that they are working in. Often, they are up against a brick wall all the time when trying to get people out.

The other bit I wanted to come back on was the item that Kieran brought up about the allied health professionals. Transforming Your Care is very much about keeping people in their own homes. As we know, the allied health professionals are an integral part of that. They are coming to speak to us later. We have all met with them, and they will be highlighting other issues.

I want to get back to Kieran's point about the AHP lead officer. I brought this up in the Committee several weeks ago, but it was my understanding that we had a lead AHP officer in the Department and that the position is becoming vacant. Is that correct? Are we in the process of filling that post? I just want to clarify that.

Dr McCormick: Yes.

The Chairperson: Has that been the case over the years? The position is up on 1 April.

Dr McCormick: We are working on it.

The Chairperson: This year?

Dr McCormick: Now.

Ms P Bradley: Will you will get that filled by then, because that is next week?

The Chairperson: April Fool's Day is 1 April.

Mr McCallister: At least it is a Sunday.

Dr McCormick: This is not a proposal; we are looking at it now.

Ms P Bradley: I just want to know, because when the allied health professionals are in front of us, they will bring up certain concerns, and we want to make sure that that is taken care of. Kieran asked about it, but it was not clarified to me that that was being done.

My earlier point, which was aimed more at John, was that people are doing this job. Nurse practitioners are discharging patients, and everybody is pulling together. I know; I have been there. I know what it is like on a Friday when you are trying to get the ward cleared because you know that A&E is going to go mad over a bank holiday weekend or whatever it might be. You are banging heads until all the balls are in the air. Inevitably, most of them fall in the right place, and discharges happen one after another, but that can go on very late into the night. We are not doing the patients a service by telling them at 9.30 am that they can go home while, in some cases, not getting them discharged until 8.00 pm or 9.00 pm.

Mr Compton: I agree with you. That is the point that I made earlier about the evidence base, because we know what works and what causes things to be problematic. I am not picking on pharmacists, but we know that, if the pharmacy is late, if the ambulance is late or whatever it happens to be is late, or the doctor is not there —

Ms P Bradley: It is generally late because the doctor's letter has been late, not the pharmacy.

Mr Compton: I understand that, but we know the evidence. Therefore, the expectation is that there is a challenge to organise and make sure that the system works in a way that delivers a proper, safe and responsible response to individual patients. That starts with an estimated date of discharge on day one. All those sorts of arrangement should be in place. As I am sure you know only too well, if you do

not have that system in place right from the start, you begin to get into difficulty. That is where everybody's 15 minutes matters. That is the important issue: it is not that 15 minutes is particularly a problem; it is the system. If you do not work the system correctly, do not have it policed correctly and are not organised correctly, you should not be surprised that people are leaving hospital at 10.00 pm when they should have left at lunchtime. That is the issue.

Dr McCormick: Linking that with last night's presentation by the Southern Trust, the application of lean techniques, which involves breaking everything down to find the steps that are required, meant that, in one instance, it had reduced a process from 137 steps to 80 steps, which cut the time of a particular function in half. Techniques exist that involve bringing the whole system together to deal with separate working and to do something joined up. Again, that is a good management technique that needs to be reinforced and fulfilled in lots of other areas.

The Chairperson: What are all the managers doing, Andrew? I accept that good work is being done in certain areas, but this is not new. We have all had experience of A&E. We have all had experience of people waiting to be released from hospital. We have managers on top of managers. To an extent, the responsibilities and roles of many of those managers are not working. You all get it in the neck, and we get it in the neck. So what are they doing? Where is the accountability? I am held to account every election, as are the members around this table. People are getting paid substantial amounts of money — we should not shy away from that, because it is public money — and have not got it right. So what are we doing about that?

Dr McCormick: We need to encourage the kind of good practice that we saw at the event last night with the Southern Trust. That is the kind of thing to reinforce. We also need to say that, if that is not being applied, there is a holding to account. It is a combination of encouraging and reinforcing the good. That event involved a group of management professionals, and we need to recognise more that people who have a management contribution to make have a professional background.

The Chairperson: Are we going to hold to account those people who do not get it right?

Dr McCormick: That was part of the discussion that was held in this room yesterday.

Mr Poots: My line yesterday was that, if people down the line fail, they fail the chief executives, who fail the chairmen, who fail me. So, we cannot tolerate people failing, because eventually it comes up the line and leads to the organisation failing —

The Chairperson: In fairness, I appreciated your comments yesterday, Minister.

Mr Poots: — and after I fail, you are out.

The Chairperson: I thought that your comments yesterday were measured. I appreciated them, because I think that they sent out the clear message that we are taking this no longer and that people are going to be held to account.

Mr Poots: You make the point to us, as do people on the medical side, that they feel that there is often so much management that they end up spending valuable time responding to management when they could be providing care. I want people on the medical side to provide me with the evidence to back that up. If that is the case, it must be responded to, but we need the evidence base to do that.

The Chairperson: OK, and I think that the whistle-blowing exercise is a good way to go about that.

Mr Poots: Yes. We need to get the —

The Chairperson: Sorry, Paula, I cut in there. I was getting a wee bit annoyed.

Ms P Bradley: Why, Chair?

The Chairperson: It must be the sun going to my head.

Ms P Bradley: It must be.

The Chairperson: Are you finished with your questioning?

Ms P Bradley: Yes, I am. Thank you.

The Chairperson: John? I hope that you are last but not least this Saturday.

Mr McCallister: I am nearly frightened now. I apologise to the Minister and John and Andrew for being late.

I suppose that, in delivering this, the big challenge for you, Minister, and for your team is how you pull all those things together to make it work. From the point that Pam made about using different points of entry into the system, through what the Chair just said, to Paula's comments, it is a mammoth task to pull all those things together to get the system running while continuing to deliver the service that you are, albeit with its recent problems. To pull all those things together, deliver change and move resources from the acute to the community side will be very challenging. It will be challenging to do all that and to maintain a quality of service that the public, rightly, demand and expect.

Mr Poots: Absolutely. If you win the leadership election, John, I am looking a cut for all the assistance that I have given to you. *[Laughter.]*

Mr McCallister: I will bear that in mind. I thought that you were going to say that you were looking to join.

Mr Poots: Do you want me to come out and back Mike Nesbitt at this point, just to finish it off?

Mr McCallister: That should really finish me. *[Laughter.]*

Mr Poots: We clearly have considerable issues. We can see where we want to go, and we are following the methodology on how to get there. In the meantime, however, that does not amount to a can of beans if an elderly person is waiting on a trolley for a hospital bed. It is not an awful lot of assistance to the person who has gone to their doctor complaining that they have a sore hip to be told that they will have to wait a number of months for a consultation and then for a considerable period for the operation. So, those are the things that we have to constantly work on.

I should say that, to significantly reduce the waiting list, it would take around three years to resolve that issue on the orthopaedic side and to get the staff brought in and set up, unless we buy in operations from outside Northern Ireland.

Mr McCallister: Are you likely to have the resources to do that?

Mr Poots: The question about resources is valid. We may well be handing money back at the end of this year, regrettably. The plan was too late coming forward, and a lot of the trusts would have held off their expenditure at an early point in the year. That is why we need to get the plans out at an early point and why we need to drive waste out of the system. Let there be no doubt: there is and has been waste in the system. I suspect that I will not succeed in driving it all out, but I will make a darn good effort, because I believe that there is waste in the system. We need to get rid of it and ensure that every pound that we spend is well spent.

The Chairperson: OK, Minister. This has been a very useful discussion, and we have touched on a lot of issues in and around Transforming Your Care and other matters. The allied health professionals will speak to us next, and they have provided a very good paper, which we can pass on to you. I want to ask you about what the Scottish Government are doing and what is happening in England with physiotherapy and self-referral. Was there a proposal to have a pilot programme on self-referral for physiotherapy?

Mr Compton: I would need to get the details of that. I do not have the details to hand.

The Chairperson: We can give you and the Department a copy of this paper, because it contains some useful points.

Mr Durkan: I think that I have a nurse fetish or something. I have another question to ask about nurses. The Minister said that it was unsatisfactory that there was such a reliance on bank nurses. One of the other issues that the RCN took up with us was that the bank is now largely made up of full-time nurses. Therefore, when the time comes that they are required, for example, in December and over Christmas, the reserves are not in the bank.

Mr Poots: If someone has been working full-time already, they might be taking on more hours. That is an issue. They might need the money, but it is about whether we are getting the best quality out of them at that point. If someone has already done 37 hours in the week and they do another couple of shifts, are we getting the best out of them? That is a fair enough point.

Obviously, Antrim Area Hospital has moved from that situation. It has recruited for 40 permanent positions. The Royal Victoria Hospital has been recruiting for permanent positions as well. We need to get to the point where we have a little flexibility but where the vast majority of staff are permanent.

The Chairperson: OK. Is that your fetish sorted?

Mr Brady: Do you want to talk about it, Mark?

Mr Durkan: Not here.

The Chairperson: Minister, Andrew and John, thank you very much for your presentation.