Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Transforming Your Care

4 July 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Transforming Your Care

4 July 2012

Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

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

The Chairperson: As this is our last meeting before recess, I want to take this opportunity not only to welcome Andrew, the Minister and John but to thank you all. In my time as Chairperson over the past months, we have had our problems, and I assume that we will still have our problems and difficulties. However, you have been accessible to me as Chairperson. I am trying to start on a high note. We will end on a low note. *[Laughter.]*

Mr Wells: Madam Chair, that sounds awfully like a valedictory speech. You are not leaving us, are you?

The Chairperson: I hope not. It is important to say that we have had regular battles but that everybody wants the same outcome. I want to recognise the fact that you have been accessible to me. That does not mean that we will not be fighting again come September. Minister, I will hand over to you for your presentation and then invite questions from members.

Mr Poots (The Minister of Health, Social Services and Public Safety): Thank you for the invitation to brief the Committee on 'Transforming Your Care' (TYC) and the progress thus far. I also thank you for your comments. I always take the view that the better informed people are, the better decisions they make. Therefore, I will always want to keep the Committee as well briefed and well informed as possible. I will always encourage my departmental officials, people in the trusts and so forth to do that. Sometimes it does not work, but we will always put pressure on them to ensure that, where possible, that is the case.

I made a statement to the Assembly yesterday to provide an update on 'Transforming Your Care' with a particular focus on the population plans. Committee members will have an opportunity to read the statement and may have read the draft strategic implementation plan and population plans, or perhaps

not; who knows? Therefore, I will not spend too much time making my opening remarks. However, there are a few points that I would like to highlight.

As stated yesterday, 'Transforming Your Care' is a response to the need for a major and overdue reform of our health and social care services. In some respects, we are ahead of the pack vis-à-vis other countries. Others will look at what we are doing and follow in due course. However, we need to take steps now to ensure that we have a system that is safe, resilient and sustainable into the future. This reform will affect all areas of health and social care; it is a reform needed by those who receive care and those who deliver it.

We need to improve the services for our population and create a better, person-centred care system that is built around the individual as opposed to the institution, while also securing improved productivity and value for money. 'Transforming Your Care' has the potential to make a huge difference to how we plan and deliver health and social care services. Implementing TYC will help to realise the vision of improving the quality of care, ensuring better outcomes for patients and clients, and enhancing the experiences of health and social care for all our service users.

A key milestone was the development of the population plans. The plans will provide the basis for taking forward many of the proposals in TYC, particularly in respect of service configuration and the shift of services from secondary care to primary and community care. Population plans will identify the strategic needs of local populations based on demographics and population health trends and identify how those needs should be met.

The population plan process has been the focus of much detailed and intensive work over the past few months. I recognise that the deadline for the receipt of the plans was challenging. However, I wanted to ensure that there was a focus and momentum to this work so that people using our health and social care services, as well as those who provide them, can see improvements as quickly as possible. The five draft population plans are complemented by an overarching draft strategic implementation plan, which was produced by John and his team in the Health and Social Care Board. The strategic plan sets out key commitments and milestones over the next three years, both at the Northern Ireland level and the local level as reflected in each population plan. A fundamental principle is a shift of service provision, moving treatment and care out of the hospital sector and into the community, closer to people's homes. Integrated care partnerships (ICPs) are to be established to bring together health and social professionals to work together to deliver better services for local populations and enable targeted care in the community, and, if appropriate, in people's homes.

Transforming Your Care covers the whole range of health and social care services. However, not surprisingly, one element that received significant attention is the reconfiguration of our hospital services. The strategic implementation plan highlights the need to guarantee the future sustainability of all our hospitals by ensuring that all acute services adhere to best practice in quality outcomes, infrastructure and staffing. Where there is fragility in hospital services, that will need to be addressed. Some hospitals would be expected to change as part of a network, working together as partners and providing services to the local population. All the draft population plans include proposals for the hospitals configuration for each of the five LCG areas. I will look to clinicians who work in our health system to advise on the safety, sustainability and resilience of the services provided, and decisions must ultimately be based on such considerations. I want to stress that no decisions have yet been made about future hospital configuration. These are proposals, and it is appropriate that we take time to consider carefully the material that has been produced.

The population plans and the implementation plans are draft documents, so they will be subject to quality assurance work over the summer. There will be engagement with clinical leaders on the drafts, and they may therefore be subject to refinement until the quality assurance and engagement processes have been completed. Once I have agreed the plans, they will be subject to formal consultation over the autumn in light of the comments received. A key objective of the HSC review was to ensure engagement with stakeholders, to enable informed debate and to present information to the public. The review itself included significant stakeholder engagement and consultation, including an online survey, a household survey, a series of workshops and a series of six public meetings held across the region, facilitated by the Patient and Client Council.

The consultation in the autumn should aim at ensuring that people are informed and engaged. It needs to be a meaningful and comprehensive consultation about the future of the health and social care sector. The plans for the consultation will be drawn up in the coming weeks, and I expect that it will include a range of vehicles to inform and educate the public, including extensive use of electronic communication, local press and public meetings to raise awareness of TYC and issues that need to be

addressed. Further public consultation will be undertaken on any significant service changes proposed in light of the conclusions of the population and strategic implementation plan.

None of us should be under any illusion that it will be an easy process or that there will not be difficulties ahead. There will. However, if we let things continue as they are, we will not be able to meet the demands on our healthcare system into the future. I appreciate that some might say that we are not moving fast enough, but changes of magnitude need to be planned strategically and carefully, and managed effectively, so that we do not introduce instability to the system and that we deliver changes in a coherent way. When members consider the detail that has gone into the planning documents released yesterday, they will appreciate the efforts that have already been made in a short time scale.

I am not complacent; I appreciate that a substantial amount of work will need to be done. My focus is on ensuring that the quality of patient and client care is protected and improved through the transformation process. I am pleased that progress is being made in line with the timelines envisaged in TYC, and that they have reached a significant milestone with the development of the draft population plans and the draft strategic implementation plan. We are very happy to take questions, Chair, at your discretion.

The Chairperson: OK, thanks very much. I have said a number of times that although people have heard the headlines of Transforming Your Care, they do not really know what it means or the impact that it will have on them or their community, so it is important that we get as much information as possible across everybody's door, because you do not want people only to become aware of what is happening when they need the service. That proactive work needs to be welcomed. We got a tabled paper from the Human Rights Commission. I do not know whether you have seen it, but the Human Rights Commission states that a human rights impact analysis should be conducted to assess how any policy decision or resource reallocation might impact on the Executive's ability to fulfil their obligations under international human rights legislation, in particular article 12. If you do not have that, we will give you a copy of it as it is now in the public domain. The point was raised with me that it is normally good practice for the Department to carry out risk assessments on policies. Having picked up and read that paper, I want to ask this: was a risk assessment done on 'Transforming Your Care'? If so, what was the outcome? If not, why not?

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): We undertake such impact assessment at consultation stage. As we equality-assure the work on the strategic implementation plan and population plans over the next few weeks, we will definitely do a screening, as we are obliged to do under all the established legislation, and consider what further processes are appropriate.

We need to look at the issues that are raised here; I am grateful to Mr Gardiner for a copy of the document. We need to look at it very carefully and consider those issues in particular. There is the equality impact issue, and we need to do a screening in that context. We need to be very careful to follow good process on all the issues and hence ensure that the public interest is fully served. We are in a pre-consultation phase of the work, and the more formal stages begin in September. That process has been completed, and we will look very carefully at those issues.

The Chairperson: A risk assessment will definitely be done on this. I have heard of the equality impact, but I have never heard about a risk assessment.

Dr McCormick: It is not deeply familiar to me. We will need to look it and take care to ensure that we fulfil our appropriate obligations. We will do that.

The Chairperson: OK. Andrew, will you give us more detail of the risk assessment? Is a risk assessment carried out on all policy that comes out of the Department?

Dr McCormick: The process that I am familiar with is routine equality screening and other forms of impact assessment . I am not so familiar with risk assessment in relation to human rights obligations, but we will get it checked out. The right processes will be fulfilled and followed.

The Chairperson: If you are not going out for consultation for some months, that is OK. Will you give me some detail of the implementation group and the local health economy group? I heard about those two groups for the first time only a few days ago.

Dr McCormick: I place the emphasis on the work that has been done. Over the past months, John and his team have led a very forward-looking process to draw together something that is based on a principle established in the legislation and the whole nature and origination of the board as an organisation in the form of its responsibility for commissioning.

Commissioning is all about planning and procuring public health and social care services. However, it is best to do that when one is well informed by the views of the providers as well, and hence to have a process that is inclusive of the interests at local level, as has happened. Health economy is the term that has been used. That term is intended to convey a sense of bringing together all the respective players — importantly, in health and social care — in each of the five areas defined by the coterminous responsibilities of the groups.

The Chairperson: Therefore they fall under the local commissioning groups.

Dr McCormick: That is right. That is the nature of it. The five population plans cover the five so-called health economies. However, it is a process that allows the commissioner in the form of John, his organisation and the local commissioning groups to embrace work with the service providers —

The Chairperson: I am just trying to get the road map in my head. When we talk about a review of public administration and all that has been done, we now have the Minister, the Department, the board, the Public Health Agency, the trusts, back to the board, local commissioning groups, local economy groups and then implementation groups.

Dr McCormick: Local economy groups are not a new entity: they are a coming together of the local commissioning group and the trust with which it happens to coincide. However, a local commissioning group is, by definition, not obliged to secure all its services from its local trust. There is a need for commissioners to secure services from other trusts or other providers. That is part of the point of having a commissioning system.

The Chairperson: Can you give me more detail on the health economy groups and the implementation and where they fit in?

Dr McCormick: They bring together existing groups to work together on this task. They have worked together to produce the population plans, and they will work together further on the population plans; however, they are not new or different people.

The Chairperson: OK, and who will they be accountable to? To John?

Dr McCormick: The accountabilities are unchanged. We had that discussion very carefully going into the process. The lines of accountability remain clear. The trusts, as providers, are accountable to the board in relation to board management, commissioning and finance; and they have a direct relationship with the Department because, as accounting officer, I have an oversight responsibility for all the arm's-length bodies. However, local commissioning groups are part of the group: they are subcommittees of the board, so we do not have a plethora of quangos or more organisations than we need. We have structures that are designed to be fit for the purposes of planning, developing and delivering public services.

The Chairperson: John, is that a result of your review of structures? Is it part of your review's outworkings?

Mr Compton: No. The point to be made clear here is that they are not new groups. The existing groups are the existing groups — trusts and commissioning — so it is —

The Chairperson: I accept that, John, but I have never heard of them. I do not know whether members have heard of them.

Mr Compton: It is a phraseology whereby we had asked our local commissioners to work alongside general practitioners and the trusts in an area, so it was put together and the working title was the local health economy group. It was all the key players in a local health economy looking at how services should relate and change, because they all have a key interest in it. It is a working group, not

a formal structure; it does not have independent governance, and the accountabilities are quite clear. It is about putting people together in one room to have a conversation about services.

The Chairperson: Are they made up of people who are on the local commissioning group?

Mr Compton: They are made up of trust staff, some general practitioners —

The Chairperson: Who determines membership?

Mr Compton: This was led by the local commissioning group. The actual production of the population plans was led by the local commissioning groups, supported by the local trusts, and in partnership with general practitioners in the area. They talked to the providing organisation: for example, in Belfast, they talked to the Belfast Trust and to general practitioners in Belfast. It was the local economy looking at how we shape our hospital services, how we care for our older people's services, and what the impact would be; clear account was taken of the impact so that the key players who would be delivering the services could say, "This would be the impact on us if you did that; we would like to do this.". There was clarity about making sure that no opinion was left to one side.

The Chairperson: Are they accountable to you?

Mr Compton: In a sense, yes.

The Chairperson: They are answerable to you and not to the trusts?

Mr Compton: Yes, because it comes through the local commissioning area.

The Chairperson: Have you a copy of the membership of the local groups?

Mr Compton: I can get you the names of those involved in each of the local areas.

The Chairperson: We will come back to that. I heard about them only yesterday. I could be wrong, but it strikes me that another tier of groups is being set up, and I want to know where it all fits in.

Mr Compton: No.

Dr McCormick: I do not agree. This was a pragmatic way of moving the work forward to allow the commissioner to work with the provider in each local area. It is a pragmatic and sensible way forward that has produced major progress in delivering the population plans on time and in a way that takes account of the concerns and issues from all the different perspectives across the health and social care system.

The Chairperson: Are you saying that the local health economy groups took the lead in preparing the population plans?

Mr Compton: The LCGs took the lead. The vehicle that they took in preparing it was to involve the local trust organisation, talk to local general practitioners and put everybody in a room together. It became common parlance that they were talking about the local health economy. Those groups exist for the purpose of delivering this; they do not necessarily have a long life, and they will not be here for ever and a day. It was trying to ensure that, in developing the population plan, all the constituent parties had a proper, full ability to influence, shape and discuss the nature of the plan. It would have been strange to have put together a plan in which a local commissioning organisation did not talk closely to the providing organisation and to the general practitioners in the area. This was nothing more than a vehicle to enable things to occur. Putting together people who are important to a decision, policy or service is something that we do all the time.

The Chairperson: OK. We will get more information. Credit to you, boys: every time you come to the Committee, I leave more confused than when I came in. You are good at it, I have to say. *[Laughter.]* I probably put that more nicely than the Deputy Chairperson did some weeks ago.

In the session after this we will talk about health inequalities, which, as you know, we are keen to deal with. Try to give me a straight answer on this. We talk about targets, but it strikes me that we are

missing targets all the time. Every other day, there is an issue about waiting-list targets here or other targets there. How will 'Transforming Your Care' address health inequalities? There are no targets as such in 'Transforming Your Care'. How will we deal with that issue?

Mr Poots: Perhaps I bear some of the blame for missing targets, because, at a very early point, I said that I was more interested in outcomes than in targets. For example, you cannot say to someone who has suffered a heart attack or other major trauma and who is waiting for major treatment in an emergency department, "Just hold on a minute. This guy has been waiting for three hours and 55 minutes to get his ingrown toenail sorted out, and I want to make sure that we meet our target." I am not really interested in that; I am more interested in saving the life of the individual who needs that.

Since I have come in, I have indicated to Andrew, John and others that targets are secondary to delivering the best outcomes for people. We are probably not as focused on targets as they have been in England over the years. Tony Blair set all these targets, and the whole mantra of the health service was to meet targets irrespective of anything else. I have a somewhat different attitude to targets. You say that TYC is weak on targets, but we identify things such as reducing the number of admittances of elderly people to emergency departments and the number of times that elderly people come to emergency departments. Those things are very important.

There are courses of work that we need to do to deliver better outcomes, and targets will be helpful in achieving that. You know that we are totally committed to the public health agenda, and we have demonstrated that financially. A great deal of work is being done with the Public Health Agency to deliver on health inequalities. You also know that I have talked repeatedly about the nine-year gap that there can be between inner-south Belfast and the suburbs of south Belfast. Some people have challenged me on that as if I were condemning people who live in inner-south Belfast; I am not. People in inner-south Belfast deserve as good outcomes as those who live in Malone, and we will continue to engage in a whole series of work to help them.

The Public Health Agency recently did excellent work with housing estates in Lisburn in my constituency that should be replicated in other areas. It identified where we are falling well short in the early years and the educational consequences of that. Children are behind when they start school; by the time they go to high school, they are further behind; and by the time they leave high school, they are way, way behind. There is so much more that we can do to help populations to have better health outcomes, better educational outcomes, better job prospects, fewer justice issues and so forth. We are totally committed to those areas. TYC will be working in conjunction with the Public Health Agency; it is the lead body on health inequalities.

The Chairperson: Was a template given to design the population plan?

Mr Compton: Yes. A format was given to everybody to look at the population plans to ensure that there was consistency in how they were presented. However, there was no proscription about what went into them. Therefore there was some clarity.

The Chairperson: I appreciate that. Was the template right across the board?

Mr Compton: Yes.

The Chairperson: Can we have a copy of it? You were probably aware that this would come up: what role did the consultants — not the medical consultants, but Ernst and Young — play in the population plans?

Mr Compton: As I said to you at an earlier meeting, they were there to support. The actual population plans were written and derived by the service, but we needed support for that. For example, there was a great deal of work on the integrated care partnerships and working closely with GPs, and they provided a great deal of assistance for the delivery of the final production. As I said to you before, it was not that the service could not produce this: with the timescale and people doing a day job, we needed support to be able to stick to the timetable. They were there in a support function. They brought extra skills and expertise as they had been involved in similar work throughout the UK. They brought a challenge function on things that had happened in other places in the UK. They asked questions, and we could say that we had not thought that out, or, no, we were comfortable with that. They brought us evidence. The proof of the pudding is the fact that we have the population plans and the strategic implementation plan on time, which proves that we took the correct approach.

The Chairperson: Finally, at this state, have we a formal view from the trusts on the population plans?

Mr Compton: The trusts were all intimately involved in the construction of the population plans, and nothing in the population plans is in any shape or form inconsistent with what the trusts considered to be the way forward.

The Chairperson: OK. I will bring in other members, although I may come back to that.

Mr Wells: Since the publication of your report, John, we have all spoken, or attended, or met delegations of groups of all the stakeholders involved. The common theme is yes, they think that you are heading in the right direction; that theme comes out time and time again. There does not seem to be any dispute about that. Someone said to me the other day that all 108 MLAs believe that you are doing the right thing, provided that it does not affect their constituency, which is a slight difficulty. Most people — the royal colleges, the unions and the health professionals — all agree that this is pushing in the right direction. I am slightly concerned, because I expected my inbox, my mail and my computer to be stuffed full of comments about your report, and I raised that with the Minister when he made his statement. One of the great surprises is that that has not happened. I have had more e-mails about dog fouling than I have had about the Compton report, and that worries me. This is one of the most fundamental documents affecting the delivery of 40% of our entire budget. I think that that is still because folk are not really engaging because, as the Minister said, we have not yet attached names to services. We have not said that service x will be affected, and name that service, although I understand why we are not yet at that stage.

I want to follow up on the idea that the Patient and Client Council had about greater public engagement. One of the things that I know it suggested to you — that meeting may have occurred — is that we write to every household in Northern Ireland and say, "Look, this is why the report was necessary, this is why we have decided to do what we are doing, and these are the implications." I do not want the right report to be delivered in a way that causes controversy. I do not want people accusing the Department of not consulting as widely as possible. You talked about the electronic media, and that is great. However, a very small percentage of the population will trawl through all the material that is now readily available. Is there still an opportunity for one major consultation exercise — more information, perhaps, than consultation — to let people know what we are doing?

Mr Compton: Over the summer, when we are doing the validation of the document and such in preparing for the formal consultation, which is likely to commence in September, one thing we will be doing is designing the consultative process. We are very sensitive to the notion that we have to make sure that we get to everybody and that everybody has to hear this, so we will be looking at the best way to do that.

If the conclusion is that the best way is through some form of household communication, I do not think there is any proscription on us doing that. We will be designing a process over the summer that will be published and that will explain to everybody how, where, to whom and about what they can comment. You are right in that there is a lot of merit in what we are saying, but people often become interested in health and social care only when it directly affects them personally, which is intermittently for the vast majority of the population. Over the summer, we will be designing that consultative process and we will be more than happy to talk to you about its nature at a point in the future, even ahead of when it will be there.

Mr Wells: So, you are saying that the Patient and Client Council idea of a leaflet to every house is one of the options being considered.

Mr Compton: Absolutely, yes. I do not think that anything is being ruled out with regard to the consultation. The real object of the consultation is how best to get to people. We learned a lot in developing Transforming Your Care. We also learned a lot from population plans. There was a lot of strong public debate across the Province, particularly at council level. We are taking all that learning, which will roll into a consultative process and we will say how we are going to consult. It will not be a secret thing; it will be a very public thing.

Mr Wells: The statement referred to contact that you had with health authorities in the Republic. I understand that that is an important component as far as Daisy Hill, Enniskillen and Altnagelvin

hospitals are concerned. On what level is that at? Are these service-level agreements, contracts or memorandums of understanding? How concrete is it that there will be a buy-in from Louth for x amount of services in Daisy Hill or that Donegal will buy x, y or z? With the new cancer unit at Altnagelvin, we have more or less got what will be bought in signed in print.

Mr Compton: The paragraph in the document on strategic implementation was agreed with colleagues in the South at ministerial level, so, there is a very strong statement here that there is to be a formal arrangement.

There is a preliminary memorandum of understanding between the two organisations about how we will do that. We will be finalising it with both jurisdictions over the summer. That will allow us to explore very directly, because we know the areas that they are keen to explore. Obviously, there are the cancer services in the north-west. They are also keen to explore a relationship between Letterkenny and Altnagelvin hospitals and between Daisy Hill, Dundalk and Drogheda. They are keen to explore a range of services, for example cath lab services, on a flow from South to North. We will also be keen to explore with them some solutions, which may be all-Ireland solutions, for specialist services and we will want to talk about that.

The important thing is to have had that framework agreed because that is quite an important step. In the past, we tended to deal with services on an ad hoc basis when there was a particular issue. Now, we have a clear statement between the two jurisdictions that they will work on those particular areas. Obviously, it will then be for the officers to create that contact. There have already been extensive contacts between some local organisations and our local border trusts wanting to look at particular services now that this direction has been agreed because it has given a freedom and imprimatur to have that discussion.

Dr McCormick: I think, as you are saying, it needs to go from a level of memorandum of understanding to contract. Once amounts of money get mentioned, things get very serious and we get down to formal negotiations that need to be turned into something that is fair to both jurisdictions and provides a fair provision of service from one to the other.

As John said, there are areas in which we need their services and areas in which they need ours. That will be sorted out. It is most advanced in relation to the plans for radiotherapy services at Altnagelvin, but there is a lot of further opportunity. We see real opportunity to make effective co-operation work but it does, as you are suggesting, need to go to the level of precise definition, and that is still ahead of us.

Mr Wells: The Chest, Heart and Stroke Association told me that there was a bid for £18 million for implementation and that the key initiatives were to get a care partnership, service changes and voluntary redundancy. As part of those service changes, there was a need to expand cardiac cath labs. We were lobbied about this at the Ulster Hospital the other day. It is clear that there is some uneasiness about the level of provision. Have you, or will you, have the funding to make the important changes regarding cath labs and stroke facilities for 2012-13 as a result of Transforming your Care?

Mr Poots: The issue is less about funding. An issue has taken place between the cardiologists as to what would best deliver for Northern Ireland. Some have the concept that you need at cath lab in each trust, and some have the concept that you could have one cath lab for all of Northern Ireland and that you would put on a helicopter and fly people into it. John probably has a different concept. Maybe he will explain it. This is not an issue of funding. It will cost us £8 million, and we will identify and deliver the £8 million to do it. John will give us some idea of where the HSCB is coming from on this.

Mr Compton: The issue is the introduction of 24-hour access, which is a major change for the population, and it is a major quality improvement for people. The money is available and the service will happen. The debate that we are finalising the work on is how best to execute that. The Minister is quite right when he said that there are, essentially, three schools of thought: one that says you have a devolved model of provision; one that says you have a very centralised model of provision; and one that says you have what might be described as an in-between model. We are finalising that. However, the issue about which of those it will be will be driven by outcomes and evidence. It will not be driven by anything other than that. Our primary focus is on what delivers to the population the prompt availability of cath labs in a timely and accessible manner. We are less concerned about where they are located, and we are more concerned about the promptness, the timing and the infrastructure necessary to make it work. We want it to work seven days a week. We will be

introducing a seven-day-a-week service across Northern Ireland. Therefore, that is really important for us.

Mr Wells: Is there an argument that some trusts are having difficulty attracting suitably qualified consultants, because they will not work unless their hospital —

Mr Compton: I understand intimately the detail of the debate that largely occurs between a devolved model and a centralised model. We have to take account of what the evidence is telling us and what is the correct outcome. We also have to be mindful as to whether it throws up unintended consequences: if you take a decision to do something, is an unintended consequence happening somewhere else? People will say, for example, that if you have a very devolved model you create fragility in that service in some arrangements. The other argument is that if you have a very centralised model, you create fragility in the places that do not have the cath lab in terms of their ability to recruit. All of those matters will be factored into the commissioning statement and the commissioning direction. We have not taken a final decision on this, but the decision will emerge during the 2012-13 year because it is an investment that is really important for the population of Northern Ireland.

Mr Gardiner: Minister, I understand that you made a bid for £18 million in the June monitoring round for Transforming your Care, and you failed on that. What impact will that have on the Department?

Mr Poots: The Department of Finance and Personnel has made it clear that it thinks that we have not fully exhausted the potential for savings. I think that Andrew is pretty exhausted with trying to identify savings. Nonetheless, he will just have to work harder on it because DFP is not prepared to hand money over if it thinks that savings can still be achieved in the system. There is a course of work for us to do. Coinciding with that, £30 million has been set aside for Invest to Save for things such as voluntary redundancy — as the Deputy Chair identified — and other elements of Transforming Your Care are suitable to bid for that. However, we can only go forward with that bid while demonstrating to the Department of Finance and Personnel that we have exhausted the course of work that we are doing and, if there are potential savings, some of them may have to wait until next year. There are areas in which savings cannot be delivered straight away. We have one course of work to demonstrate to DFP that we have fully exhausted all of the savings that we can make. That will coincide with a bid to the invest-to-save funding.

Mr Gardiner: Is there a timescale for when this will all be implemented? When will your Department see success?

Mr Poots: We can work away on this over the summer. We can bid quite early for an element of that £30 million. However, it has been very clear that we can bid only on the basis of having demonstrated that there is not the savings in the system to achieve the work that needs to be done. DFP recognises that we need to do TYC, and it supports us in that regard. It recognises that we need £18 million to do that: it says, "You identify what you can save, and then come back to us."

Mr Gardiner: When are you likely to go back to DFP? I am trying to push you for a definite answer.

Dr McCormick: The deadline for bids to the invest-to-save fund is the end of July. We want to get a bid in as soon as we can. We also want to all we can to help DFP to come to a decision on that as early as possible. As far as we are concerned, the sooner, the better in terms of confirming the mandate for the work on the four elements of the bid. They are all —

Mr Gardiner: Will it be cleared by September, say?

Dr McCormick: As you get into the autumn, it becomes more difficult. You end up with loss of opportunity through delayed decision-making. DFP is well aware of that problem. It has recognised the need to deal with this quickly but in an orderly fashion by putting us through the process of questioning that the Minister described.

Mr Poots: There were things in the McKinsey report, for example, that DFP would like to see implemented that we disagreed with. We will have those discussions. There are things in PEDU that DFP would want to see implemented that we disagreed with. We have to have those arguments and discussions to come to some sort of settlement. All of those things —

Mr Gardiner: I repeat myself: do you hope that, come September, it will all be sorted?

Mr Poots: We hope so. We do not want to be hostages to fortune.

Mr Wells: Does DFP expect you to find the £18 million on top of the £190 million that you are expected to find anyhow?

Mr Poots: Yes.

Mr Wells: That is an extra 7% or 8% on top.

Mr Poots: Yes. DFP is a hard taskmaster.

Mr Wells: If you find £190 million, I would have thought that you have done pretty well.

Mr Poots: You would have done pretty well, but it expects you to do more.

Mr Wells: Slave-driver Wilson.

The Chairperson: We will not open that can of worms at the minute; we will come back to that.

Mr Dunne: Thanks very much, Minister and officials, for coming along once again to talk about this. Overall, are you satisfied with the progress? Are you running on target in relation to the whole plan?

Mr Poots: I am satisfied with the progress. Lots of things are happening in conjunction with it. For example, the Belfast Trust has identified that it wants the City Hospital to become an elective surgery centre. Those things can happen in conjunction. That is why, at the outset, I asked John to lead this as he was leading the HSCB. It did not prevent work continuing in the HSCB because we are doing Transforming Your Care; the two things can run in tandem. A major shift will take place from secondary care to primary or community care. There is a degree of preparation for the public, and there will be a shift in funding. The integrated care partnerships are critical to the delivery of that. There is a course of necessary work that we have to go through. It is a bit like when you build a new home, hospital or anything else. Very often, getting planning permission, getting the plans drawn up, getting the funding set aside for it and all of that can take longer than the building process. There are processes that you just have to go through even though you do not see any real tangible benefits, but when you start the actual work, it can flow quite quickly. The process is moving ahead as quickly as I could have anticipated.

Mr Dunne: So, you are satisfied with progress to date. The role of GPs never seems to be out of the headlines. Obviously, there is a lot of work to be done in that regard. There is a need for funding for health centres in our large towns. How is that progressing?

Mr Poots: I think that GPs, particularly younger GPs, are beginning to appreciate more and more the direction in which we are headed, because they will become empowered to a greater extent than ever before with their patients. They will be dealing with more of their patients' care and more of their patients' needs. They will be making fewer referrals to consultants and hospitals, and will actually deal with more people. There is a strain, a burden and a cost associated with that. It is up to the integrated care partnerships to identify how best to move forward. We are probably looking at having fewer nurses in hospitals but more involved in the community. We are probably going to look at nurses in the community being better paid than they are at the moment, potentially, because they will be doing a job that will have a greater skill attached to it. It will be a terrific opportunity for many nurses to expand their skills base. There is also good news here for allied health professionals. We have a series of pieces of work that they can do for us, which is much more cost-effective than referring people to hospital.

In all of this, we think that there is an awful lot more for GPs to do. There are some very forward-looking GP practices that are already doing what we are talking about in TYC. Last week I had a very kind invitation to attend a centre in Clough. It is way out there in terms of what is provided. We have the GPs there, the optician there, the physical therapist there, the podiatrist there —

Mr Wells: Do not forget the pharmacy.

Mr Poots: The pharmacy is very well advanced in terms of the local services. The GPs are providing more and more work on dermatology, for example, and on gynaecology — far more than would be happening in a lot of other practices. That is where we want all of our GPs to be, and further, because that can be extended further. That is the scale of things. Lots of people will not be referred to hospitals to receive care.

Mr Dunne: Obviously, funding will be an issue in relation to all of that.

Mr Wells: This is private funding.

Mr Poots: The capital construction of it — again, they are ahead of us, because we are looking at a third-party development (3PD) model in both Lisburn and Newry, which, if it works there, will then be rolled out across Northern Ireland. The 3PD model has already been carried out in Clough in that instance, where it was built by the local people themselves, and the rent is paid for it. We, as an Executive, do not have hundreds of millions to plough into that, so the more that we can work with local communities to deliver that type of facility the better, because we will have really good quality facilities to deliver for local people.

Mr Dunne: The Committee has been out and about quite a bit, which is good. We have been to the South Eastern Trust, the Southern Trust and Belfast Trust. I think that we have all been impressed with the work that is going on in all of those hospitals. They certainly do recognise the need for change. From what we have seen, we feel that they are making progress towards what you want to do. Is it fair to say that they are driving change ahead of you?

Mr Poots: I think that hospitals do recognise the need for change. Take the increase that there will be in diabetes, for example. If we do not give more of those people the appropriate care, the hospitals would be completely snowed under. They need to be there to deal with complex cases that are beyond what can be dealt with at a local level. A consultant with particular expertise in diabetes, who has a team around him, including consultant nurses in diabetes, can be there to help those people who really need that, but if we send all and sundry up to the hospital to be cared for for diabetes, the system would collapse. It is in hospitals' interests that workloads that can be dealt with at a local level are removed from the hospital system, because there is going to be more than enough work, given the age base of the population and the chronic illnesses that exist within the population, for the hospitals to maintain plenty of work for themselves.

Mr Dunne: Is it reasonable to say that some hospital trusts may not have drastic change as a result of Compton?

Mr Compton: The production of the population plans is inextricably linked to trusts, local general practice, and local community professionals. It is my view that there is a strong endorsement for what is contained in the population plans from within the system. I would not be surprised that you were hearing that, because we have only reflected back what is being said here. The strategic document is entirely traceable back to things that were said in individual population plans. There is a very strong endorsement for this.

Going back to what the Minister said, things are quite powerful and, perhaps, not appreciated sometimes, but unscheduled admissions are down 10%, lengths of stay are down by 18% and there has been a 20% decrease in the number of older people attending emergency departments. These are profound changes that will affect the shape and nature of all our hospitals in Northern Ireland under the aegis of the integrated care partnerships.

When I talk to general practitioners, as we have done very extensively throughout this process, there is considerable enthusiasm. Of course, there is some anxiety about whether people will pay attention to the issues that are important to general practitioners. We have made a very strong statement that we will do that. As part of that transforming money, you can see that the amount of money is of the order of £4 million this year to begin to enable this transition to take place. There is very strong support for this throughout the system.

Mr Dunne: The measurement of outputs came up, and the Minister talked about that. There seems to be a strong interest in the trusts in moving away from time-based targets towards those based on

quality indicators. Would that support what is being done? I know that you touched on that earlier. Is it fair to say that that will be the driver?

Mr Poots: It is certainly the direction in which I want people to go. For example, we have quite long waiting lists in orthopaedics, and we want to address and reduce those lists. Let us say that someone has a major back problem that requires immediate surgery, but is told that they might have to wait six months or nine months. There may be someone who needs a hip operation, and the length of the waiting list for those operations will cause that person a lot of pain, but not to the same degree as that being suffered by the person with the back problem who may not be able to work or take part in other normal activities.

We have to focus on delivering on the things that are needed more quickly, rather than saying that we have a target to deal with hip replacements within X number of weeks or months that we have to meet irrespective of other needs. We need to focus on delivering what people need most: that is the most important outcome.

Mr Compton: I am aware of what you are saying. It is about both/and, not either/or. There is a clear correlation between a waiting time in some instances which is unacceptable, and, therefore, the measurement of that waiting time is entirely appropriate, but if it becomes the sole issue and the whole system is paralysed by that, it has the potential to become difficult, so it is both/and. Waiting, and the time that people wait, should be at the minimum, and in that sense it is reasonable to have a sense of time when people know how long they will have to wait.

However, it is equally important, for example, when we look at emergency departments, that we talk about how people undergo thrombolysis if they come in for treatment for a variety of cardiovascular issues. That is really important. The actual absolute waiting time in that regard is set aside; the clinical waiting time that might be determined by that is much more important. This is all about both/and, not either/or.

We must have some sense that time is important for people. We all know about the issues that we have had, for example, with the publicised 12-hour waits. No one thinks that a 12-hour wait, in any set of circumstances, is anything other than unacceptable. It is reasonable to have a point about that, but it is also reasonable to go to the College of Emergency Medicine to talk to them about important clinical standards for people who return to accident and emergency departments within 24 hours, and the percentage numbers of such people, because that is an indicator of whether the quality of assessment and intervention was not correct. It is about both/and in that regard.

Dr McCormick: I would add that the discussion about targets and the earlier discussion on cardiac catheterisation illustrate the value and significance of having a system that has the commissioner as the leading player. That takes away some of the power and decision-making. As you have heard, the views of providers in hospitals are important and were part of the process in producing the population plans. However, the commissioner's primary responsibility is to assess the needs of the population and use those needs to advise the Minister's important decisions. That is an important balance in the process. So, yes, we need to hear what providers are saying, what they can offer and what they think is important. The judgements and decisions, however, on how things are planned and decided in a commissioning system have to be independent of the providers and, as emerged from the discussion, there is real value in the commissioner reporting to the Minister.

The Chairperson: Kieran gave me a big smile when he came in, so I will allow him to ask one question.

Mr McCarthy: Thank you very much, Chair. I apologise for not being here for the presentation. I have an important question: did full engagement take place with the voluntary and community sector during development of the population plans, and do you have a list of organisations that were invited to engage with the process?

Will you assure us that good communications between the statutory and the voluntary and community sector will be in place, as the population plans are rolled out, and that appropriate use of the voluntary and community sector has been ensured?

Mr Compton: There are about three bits to the question. I hope that I have picked them up correctly. First, there will be involvement with the community sector, because we spend about £75 million to £80 million a year in that sector. If you spend that amount of money, they are serious players and you

have to take it, and treat it, seriously. Of course, we will want to do that, and we refer in the document to that side of things.

Over the summer, we will be preparing a process for handling the consultation that will go out in September for three months, a key component of which will be how we enable engagement with the voluntary and community sector. I will not pretend that, in producing the population plans, we had what might be called exhaustive, extensive consideration from every aspect from the voluntary and community sector. However, I am assured that we had a reasonable opinion and engagement with them, given the timescales and what we were doing in shaping the population plans. I do not think that there is any difficulty about that; we have very much an ongoing relationship in many instances, locally, with many voluntary and community sector groups. So, I am quite sure that a lot of their expressions, feelings and thoughts are reflected in the plans.

Mr McCarthy: Will you provide us with a list of organisations? I think that that is important?

Mr Compton: Yes.

Mr McCarthy: That is grand.

The Chairperson: I thought that Kieran was the last to be called, but I apologise for missing John and Paula. I did not allow him, as father of the House, to jump in front of you.

Mr McCallister: Age before beauty and all of that. Minister, I have a few thoughts on this, one of which being that Andrew may want to go back to DFP if he needs to save about £208 million. Would failure to get the four parts of the £18 million bid in September rule this out completely?

Mr Poots: No; it has to happen. This is a priority for us, so it just has to happen.

Mr McCallister: As Jim said, it adds another 6% or 7% to what you have to find, which will be difficult if the bid is not successful.

Mr Poots: There is no doubt that it would make life very difficult for us. We will be making a strong bid for money from the invest-to-save budget. I suspect that we will have to find some millions and that DFP would like us to find all £18 million of it, or as much of it as possible. We will probably want to find as much as possible, but I do not think that it will be anywhere near that figure.

Mr Compton: There are no neutral decisions in what we are doing, and it is important to come back to why Transforming Your Care happened. It is because we know that we have a system that requires change. Change requires enablement, and it is really important that the change is enabled. Although we will always have the detailed conversations with our colleagues, I have not sensed any resistance on their part to try to support the change. Those tough discussions will always go on about money and who gets what, but it is clear that, in this process, there are no neutral decisions. If we were unable to properly get to a proper financial base, it is not as if there would not be any cost associated with it, because we know that, if the current system does not make the change, it is not in a neutral position. It is really important that we are able to do that, and, from our point of view, we are thoroughly engaged in ensuring that any information that is required is available.

Mr Poots: We are making a decision about the £8 million that the PCIs will cost. We are making decisions about telehealth and telecare, which are costing £18 million. We are making decisions about electronic care records, which are costing £9 million. We are making all those decisions against a backdrop where there are huge challenges in A&E, where there are issues about drugs, and all of that. Therein lies the difficult circumstances that you find yourselves in. There are some very worthy things that we will not be doing, and some things that we are investing in. For example, we are investing in bowel screening. That will save lives, and it will save us costs in the future, but it means an investment now. An awful lot of what we are doing now involve an investment now, for example, the public health agenda. If we were to take £100 million out of public health, we would have loads of things to spend it on. It would be absolute madness to do that, because we would end up spending a huge multiple of what we had saved, and that would perpetuate year after year. These are the difficult decisions that we have to make. There are things that we do now that will deliver in the future, and, as a consequence, we will probably cause ourselves some pain in the present.

Mr McCallister: I have always been supportive of the public health agenda. Minister, I was encouraged by your comments yesterday in your statement and in your answers today on early intervention. Sometimes, I am concerned that we have talked about early intervention ever since I was elected here and probably for a good number of years before that. How will we take that to a new level, and how will you get your colleagues around the Executive table to remember that health is the business of other Departments? You have held other portfolios as Minister of Culture, Arts and Leisure and Minister of the Environment. It is about getting other Departments to buy into the idea that we all have a duty on that. I have long since accepted the argument about early intervention, educational outcomes, parental responsibility, the link with the criminal justice system and the lack of people who will be part of the wider economy and involved in economic activity. You have a big challenge to get others to buy into what I agree is a very worthwhile agenda. The rewards will be enormous, but how do you feel that you will be manage to get them over the line on some of these issues?

Mr Poots: I would not say that there is unwillingness. There are challenges, and maybe people are not as convinced as I am at this stage about the benefits of early intervention, particularly with the parenting of younger children. I have seen so much evidence, going back to when I chaired the Committee of the Centre in 2000, when we did a report on the children on appointing a children's commissioner. We have lost a decade, and, if we hang about for much longer, we will lose an entire generation. In 2000, we talked about how children were being missed out and not getting the opportunities of many other families. They will be coming into the system and having children, and the same thing will happen all over again in the very near future. There is a huge challenge and a huge incumbency on us all to step up to the mark. I see the Department of Education as a key Department in conjunction with our Department. Others have a role: DSD, Justice and DCAL all have a role to play. However, if the Department of Education and the Health Department say in a determined way that they will do this and make it happen, it can happen. I am determined that it should happen and I would like my colleague in the Department of Education to be as keen on it as I am.

We will make the investment, set money aside and do this, even though it is challenging, because the outcomes will start to eat into that vicious circle that keeps replicating itself, not even in a generation but probably every 15 years. We need to bite into that and start to reduce it.

Mr Compton: Specifically, we mention the Roots of Empathy programme, family support hubs and family nurse partnerships as tangible service provisions as part of the population plan, so there is, as the Minister rightly pointed out, a need to work conjointly with other Departments. Irrespective of that, and recognising our own responsibility, the strategic document has specific proposals with regard to children, supporting children into the future and changing the pattern of care. This is all about reducing the high-end expenditure and giving children a better quality of life as they grow up, and a better ability to manage education and have better life choices as a consequence.

Mr McCallister: Of course, John, it very much identified that families need that support.

Mr Compton: Absolutely, and the programmes that I talked about are very evidence-based and show that you can identify the families who are most vulnerable and at risk, and you can put the emphasis on those families and make material change. These are not just programmes with a hope that maybe something will be better. They are well researched and well evidenced, and we are convinced that you can make a material change as a consequence of the introduction of those programmes.

Mr Poots: There are large families with all the children in care who are costing the public purse £10,000 a week. We really need to provide an awful lot more help around that. If the investment is made at the early point, we will save huge amounts of money in future years. All the evidence shows that, if you make the investment in the early years, the benefits are far greater than making the investment in later years, and the cost of investment at the later point is so much higher. The whole logic drives us to this point. There is a willingness on our part to do considerably more than we are currently doing. We recognise that it will involve a degree of sacrifice in some other areas. Nonetheless, we think that it can deliver real and tangible benefits.

Mr McCallister: Not only would the cost be significantly higher but the outcomes could be significantly worse.

Mr Poots: Yes, youngsters getting jobs instead of ending up in jail.

Mr McCallister: I want to bring you back to the discussion on the trusts, LCGs and health group economies, and about making sure you get private independent sector and community and voluntary sector involvement in that. I agreed with your reply to a question yesterday, Minister, when you refused to rule out having other sectors involved in health. The question was maybe urging you to legislate against having any other involvement. It is important that other groups are involved. I would even like to see groups that can deliver services maybe more efficiently than the public sector can being allowed to tender for those services or being on a level playing field. Do you see giving more power to commissioners as a mechanism to try to drive some of that change?

Mr Compton: We referred to the procurement issue specifically because we have to. Frankly, we have to sort out our procurement issue here. There are all sorts of legislative constraints on us to sort that out but in a sensible manner. If you went into some sort of wholesale procurement thing without thought, you could have major unintended consequences with regard to the voluntary sector. For example, a small parents' group doing invaluable work in an area may find itself completely unable to compete in a commercial way. The issue about procurement is to have financial and non-financial criteria but to have them clear and with a level playing field and to have access to that. We have talked about diversity of services, and that means that some of those services will be provided by the statutory side and some of them will be provided alongside the statutory side. What is important is that we get a mix of those services, but that we get it on a flat and level playing field. Again, the strategic document makes it clear that this is an important objective for us, because it is imperative to sort that out.

Mr Poots: Again, we would see great opportunities to engage with the voluntary and community sector on some of this stuff. That sector very often can deliver a better mental health service at a lower cost. Also, I know that, in the Chairman's constituency, an initiative has been running in Colin whereby the local community are providing domiciliary care and it is done in a very professional way. I think it has lifted over 60 people out of unemployment. Quite a number of them have moved on to other jobs and other opportunities, but those were people who were previously unemployed.

Mr McCallister: It is almost like a social enterprise.

Mr Poots: Yes; a social enterprise delivering domiciliary care in the local community. There are local people providing care for their own community, and it was organised as a social enterprise. I think we need to support and encourage those types of activities. In some sense, that goes beyond health, but, nonetheless, the outcomes are very good for Northern Ireland plc. I have spoken with people in my own area about seeing how they could replicate what is being done in Colin, and I think that others should look at those kinds of opportunities.

Mr McCallister: That is almost building up a sense of community in areas as well.

Mr Poots: Yes. We are trying to work on a procurement process whereby, if some of these things cost us a bit more but there is evidence of other significant and tangible benefits coming from it, we can take that into consideration. If a private company, perhaps a company from England, comes over and says that it can deliver this for 3p an hour less than you are doing it, but there is a host of other advantages to paying our own social enterprise that 3p an hour more, it will allow us to do that.

Mr McCallister: Are you likely to have to make any legislative changes, or are you pretty well guided through the —

Mr Compton: I do not think so. I think the procurement issue is more to respond to existing legislation and to get existing legislation to a better place, because a lot of the contracts that we have had in the past have been historical, and we need to get them into a more up-to-date platform. However, the Minister is correct, and from a commissioning point of view, we are very strong about the non-financial criteria as well as the financial criteria. This is a total package, so it is very important that there is appropriate and equal weight given to both of those things. Of course value for money is important, but it is not the only determinant in this particular situation, particularly where you have an interest such as the Colin project, which I know very well from a previous life, or parents' groups, particularly in the field of learning disability, who want to do things and do it in a certain way. You have to enable that, because it is adding a tremendous value to the level of care. What is important is that we make sure we have got the platform to do that to help. Again, in here, we are very clear about that and very clear about making sure that diversity is there, because the diversity is giving people extra choice; not absolute choice, but extra choice inside a world that is realistic.

Mr McCallister: One of the frustrations I have with the public procurement system as an elected representative is that people get very frustrated getting into the system. If you go to start up a new business, even if it was like a social enterprise, people have difficulty getting into the system, and sometimes there is a frustration over whether like is being compared with like if the trust is providing some of those services. The following question is asked: can the community and voluntary sector tender for that, or is everybody on a level playing field? You have to make sure you are not only benchmarking against the cost but the quality, which you mentioned. I do not think that, even from a community and voluntary sector or independent sector point of view, people mind not getting a tender if they feel it is fair and is because of the process.

Mr Compton: I think that is the issue. It is about making the procurement more explicit and straightforward. That is really what we are talking about having here. It is so that there is that sense of fairness in the issue. That also addresses some of the legal issues that we have to quite properly and appropriately be mindful of in the way through, but it is about existing legislation, as I would understand it at this point, rather than anything that requires new legislation per se.

Mr Poots: We cannot afford to drop the quality of care, particularly when we are dealing with vulnerable people in mental health and domiciliary care. Everybody was horrified last year, when they heard on the news about a lady who was eating the food of the person she was supposed to be caring for, because she did not take the time to feed her. Things like that are totally unacceptable. We always need to ensure that the quality is good, irrespective of who is providing it. That has to be the standard that is passed by every group, regardless of whether it is a social economy group or anybody else.

Mr McCallister: Presumably, Chairman, the RQIA is used to monitor and to be the watchdog of that, where possible. I know that you cannot have somebody monitoring every single home.

Mr Poots: No, you cannot, but it is important that information comes forward to the RQIA. If people have any doubts or suspicions, they should act upon them, as opposed to wondering what is going on. If they are not happy about what is happening, they should do something about it.

Mr McCallister: Yes, they should do something.

The Chairperson: We will leave it there, because we will come back to the RQIA and some of the issues around that regulation in the near future.

Ms Brown: Thank you for your presentation. Minister, I was glad to hear your comments in relation to nursing. I know that many here are anxious to hear that jobs in the health service are safe, so your comments will have been of some comfort to them. Recently, I heard some comments about bursaries, for instance, being paid, and a question was asked about whether we were training too many nurses for the jobs available. I would like you to comment on that.

Yesterday, you made comments in relation to the Causeway Hospital. What impact, if any, do you see that having on the Antrim Area Hospital?

Mr Poots: We had a discussion with the RCN last week about nurses and their bursaries. The RCN is keen that we continue to train an adequate number of nurses. It indicated that a large proportion of our nurses in midwifery and some of the paediatric nursing areas, for example, are over 45. Perhaps Mr Dunne and I should declare an interest in that. Nonetheless, that is the case in some instances. We have a problem in that we train young nurses, and a lot of them do not get jobs here. A lot of them go to England. A lot of them return, but some do not. They get good experience there, and they come back with that experience. Workforce planning is a difficult management process, because it is difficult to identify how many nurses are going to be leaving over the next five years and how many nurses should be trained. I would prefer to train too many than to end up in the circumstances we were in a decade ago, when we had to bring in quite a lot of nurses from India and the Philippines. They were absolutely grand nurses; they were really good girls and all of that, and I have absolutely no issue with that, but we should not have got to the position where we had not trained an adequate number of nurses to fill the spaces here in Northern Ireland. We will seek to avoid that issue at all costs. It is better to train a few more than you need than not to train enough.

You also asked about the Causeway Hospital and Antrim Area Hospital. There will be implications, in that the model that the Northern Trust is looking for is one hospital on two sites. There will be something different about the whole management of both of those hospitals. John will beef that out a little more in respect of what the population plan might be and the two facilities.

Mr Compton: One point I would make ahead of that is that part of the strategic investment document has a workforce part to it, so there is an integral bit about workforce and how we handle workforce. It is, therefore, seen as being quite important that we get the workforce into the right shape to be able to deliver on the other side.

The Minister is correct with regard to where we are locally and the population plans. We have been pushing to see no hospital standing as an island to itself, but to work together. If you go to the southern area, for example, you will see that surgeons perform surgery across the two hospitals in Daisy Hill and Craigavon. They operate in both; they decide the level and acuity of illness that can be treated in one and with the other hospital. We will be seeing that sort of movement between Causeway and Antrim. Because of location, there will also be discussions with the Altnagelvin side. There was a lot of stuff and speculation in the press about Causeway and whether there would be doctors at the front door and such issues. The more profound changes are to do with integrated care packages. If we reduce the number of people going into hospital, we will change the nature of hospitals. When the cardiac cath labs are introduced, they will change how hospitals operate not just in Antrim but throughout Northern Ireland. So, I do not think that we are trying to denude an area of a reasonable acute service. It will have a reasonable acute service but, as the Minister points out, it will be changing. The nature of surgery will be changing, the nature of what comes in respect of the medicine will be changing, and the nature at the front door will be changing. However, that will not just happen in one particular facility; it will happen right across Northern Ireland.

I think that there is a very positive future for both facilities. What is quite clear is that about 400,000 people live in the area and those 400,000 people need access to acute services. So, it is about getting the two facilities organised in a way that enables them to deliver the services that those 400,000 people need. Not all of them will be served locally, because some might have to go to specialist services in Belfast or whatever, but it is about doing that sensibly and correctly.

Ms Brown: I think that there is a very positive message throughout 'Transforming Your Care'. Jim raised a point earlier about the lack of awareness among the public. I think that he is right: it is only when this starts and things are being named that people will become aware of it. Nobody doubts the need for major change; it has to happen. I think that it would be great to hear some good news stories about how services could be provided in the future. I think that would be fantastic.

Also, early intervention is an absolute necessity. It is a brave step to invest in that, because it obviously takes a long time to realise savings from early intervention. However, from the evidence I have heard during presentations in this Building, I think that it is very worthwhile. Thank you.

The Chairperson: OK. A lot of issues came up throughout the presentation, and we have asked for further information. Minister, are you content that we get a further briefing from you in September, when the population plans and the strategic plan have been finalised? In the meantime, can we get the information we asked for so that the Committee can get head its head round some of the stuff?

Mr Poots: As long as we do not confuse you more.

The Chairperson: You confuse me every day.

Mr Poots: You have all summer to go over it.

The Chairperson: Those two lads are experts in it; trust me. On behalf of the Committee, I want to thank you for coming today and for providing the paperwork.

Mr Poots: I wish you all a good summer.

The Chairperson: Thank you.