Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Transforming Your Care: DHSSPS/HSCB Briefing

10 October 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr John McCallister
Mr Kieran McCarthy
Mr Conall McDevitt
Ms Maeve McLaughlin

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: Agenda item 4 is an evidence session on Transforming Your Care (TYC). We have a packed Gallery this afternoon. Everyone is more than welcome. I refer members to the copy of the Minister's statement to the Assembly yesterday on page 3 of the tabled items and welcome to the meeting our favourite boy band, TYC. *[Laughter.]*

Mr Edwin Poots (The Minister of Health, Social Services and Public Safety): I'm Ronan. *[Laughter.]*

The Chairperson: You are the lead singer.

Seriously, I welcome the Minister, John and Andrew for an update on yesterday's statement and to give us an opportunity to go into more detail on some of the stuff that was announced. I will allow the Minister to make a presentation, after which I will open things up to questions and comments.

Mr Poots: Chair, I made a fairly long statement yesterday and I see that I will be making a fairly long statement today. To be honest with you, I will be repeating a lot of what was said yesterday, so, if you are happy, I am happy to go straight to questions.

The Chairperson: OK, Minister.

Yesterday's statement probably gave more detail than we have had over the past while, which is useful. I have read it a number of times now and have a couple of points to raise. I know that it is going out to consultation and that you confirmed that an information leaflet will be sent to every household this time next month, but I want to get into some of the issues. My questions are not based

on what has been in the media, but I note that certain media reports have mentioned job losses, the closure of residential care facilities and the networking of hospital services. Would you explain to us the rationale behind some of the options with regard to the networking of hospital services? Has there been any discussion with senior management or even clinical directors as to whether that is the best approach from a clinical or even population plan point of view? What other background discussions have taken place with some of the vested interests, including the unions?

Mr Poots: Some of this has been happening incrementally in any event. For example, for people in Fermanagh, particularly since the new road was developed, there have been more linkages to Craigavon and perhaps, on occasion, Altnagelvin. However, no significant change has been proposed in that respect. The more significant change has related to the link between Causeway and Altnagelvin as opposed to Causeway and Antrim.

Looking to the services that will be provided in future, we are looking at enhancing the orthopaedics unit there. So if someone has a fall and has a fracture that needs to be fixed at a fracture clinic, that is where it will be most readily available to them as opposed to travelling to Antrim and then to Belfast.

There are already very good urology linkages between Causeway and Altnagelvin through the satellite radiotherapy unit. Why would someone in the Coleraine area want to travel to Belfast when they can get that treatment at Altnagelvin? That sort of thing is happening quite naturally, and indeed the 24-hour catheterisation laboratory is providing the highest level of care that you can receive if you have a heart attack. That is the best hospital care that you can receive. That will not be available in nine hospitals across Northern Ireland, but in two, and having the service at Altnagelvin might bring more people from the Republic of Ireland. That is a course of work we need to continue with, but that may be available there. All those things will naturally draw people to Altnagelvin.

I should say that, in spite of some rather foolish comments, none of those services is currently available in Causeway. If anybody is saying that the services are being stripped out of Causeway and taken to Altnagelvin, that is just wholly untrue.

I suppose that the other aspect is that we have a number of vacancies among our consultants in Causeway; I think that there are six vacancies at the minute. Those vacancies have existed for some time, and there is trouble filling them. We have locums who are filling the gap, but filling the gap does not make up for having sustainability and permanency. One of the things that TYC originally referred to was weaknesses in relation to locums.

In spite of quite a number of efforts by the Northern Trust, it has not been able to fill those positions. The truth is — and this is where the real fragility lies with Causeway — that a consultant will want to have their skills tested and to have a capacity that will allow them to maximise the work that they are doing and to develop their skills to the highest degree.

Most up-and-coming consultants in their 30s do not see Causeway as attractive to them. That puts a real fragility on the entire hospital. However, we are of the view that if consultants were appointed between Altnagelvin and Causeway, they would be able to do all those things. Although they might not be permanently at either site, it would be something that would help us to sustain quality services at the Causeway Hospital.

Far from accusing or suggesting — and it is only a suggestion at this point — the Western Trust as something to strip services out of the Causeway, it has a far greater chance of making the Causeway a sustainable hospital than if we just do nothing. If we do nothing, we will get nothing. If we want to make a change to support the services there, we need to take some actions.

That is the thought process behind the networking. We already have networking across hospital trust boundaries in quite a lot of areas; there is quite a lot of networking between Belfast and the south east, for example. In the areas that you represent, most people would go to the Royal, but they are in the South Eastern Trust area and quite a lot of my constituents would do the same. At the same time, people will be using plastic surgery services in the Ulster Hospital in the Belfast Trust, and the 24-hour cath lab that is available in the Belfast Trust will be used by people from the south eastern and southern areas. So, this crossover between networks and hospital trusts is something that can exist and can work. They do not have to be isolated in that respect.

I will ask John to cover some of the details on the residential homes. I think that we have one residential home with no permanent residents — it is used for respite care. We have other residential

homes with four or six people in them. Most of them are not operating at above 80% capacity. That is probably not a good use of our resources.
Many people will say, "We pay for a good residential home in our area, people have been using it for years and we do not want to see family being moved out of it and all of that." Those will be the debates and issues that will come up. There are a lot of residential homes that, at an early point, would not cause an awful lot of that because there are very few people in them. Perhaps John can give us some more detail on that.

Mr John Compton (Health and Social Care Board): There has been a change in this model of care, which has been going on for a number of years. It is important to state, first, that we are talking about residential care, not nursing home care or specialist care for the elderly mental infirm or those who suffer from dementia. The nursing home care and elderly mental infirm groups are not part of this. This is about residential care where, in many instances, individuals are able to provide a fair bit of their own personal care.

Over the past number of years, there has been a change in the demand for that. That is a consequence of two things: improved home care and the development of housing with care. We now have many schemes throughout Northern Ireland in which housing with care is an alternative.

It is about changing the model of care. The consultation document states that the number of statutory homes will be reduced by "at least 50%" in three to five years. That involves doing two things. It involves responding to the population who might first come in to that care to divert them to alternative care, and handling sensitively the residents who are in those homes while not doing anything precipitously that does not in any way involve a lot of engagement and discussion with residents and their families.

There are 168 residential units in the private sector, so it is not that residential care will not be available. Even given the figure of "at least 50%", there will still be some statutory care because there are some compelling arguments from time to time about social isolation for one or two individuals where that is an important issue and where there is no availability of housing with care. However, looking at the proposed drop of around 750 places, we know that there is in the independent sector at present a vacancy gap of around 10%. We also know that in our housing, we are expecting another 480 places to come on stream over the same period, so they are netting in with the other, and it is about changing the model of care here.

When we talk to people and ask them what sort of care they want, they overwhelmingly say, "Please, I would rather stay at home and have my services at home." In the end, it is about a shift in where we spend money. If we choose to spend it here, we have less to spend in supporting people in their own homes. The shift is to spend the money in a different way.

To reinforce that, if we look at the TYC document, there is only a 5% shift, of which £41 million is going into community care services. That is an increase there of 9%. It is a large increase in that sector to enable us to provide better care at home, but it requires a shift in the model to allow that to occur.

The Chairperson: Okay. I will go back to that specific point. I always try to look on the positive rather than the negative side, and I have always given Transforming Your Care a guarded welcome. I have tried to see the vision, and I appreciate where we are.

However, I want to try to work out the issue, because we are now getting more detail on where we need to go. You headed up the group that gave us Transforming Your Care". We have been told all along that it is about ownership and a partnership approach, whether that is from the community, the patient, the stakeholders, the professionals and the vested interests. I am trying to work this through in my head. Was the group that was involved originally involved in this stage of the statement?

Mr Compton: No.

The Chairperson: We are talking about moving people from the acute sector back into the primary community sector. Was there GP involvement in the issue of networking hospitals? One of the criticisms of our hospitals was that there were referrals from GPs to hospitals that should not have happened. If we are talking about configuring hospitals, at whatever level, was there clinical involvement in making a decision? Were GPs involved in that?

Mr Compton: In the hospital situation, we must remember that the document comes from the population plans that were developed in June, which were quality assured over the summer period.

In the Causeway issue, and in any of the population planning around Causeway, which involved lots and lots of people — clinicians and everybody — the overwhelming issue was fragility. Left standing, as it is, on its own as an isolated facility, it was too fragile and too problematic. If we did not create some alternative future for it, we were going to run into a set of unplanned changes. There were a lot of people involved in all that.

The Chairperson: I appreciate that, but is there any plan for what is happening now, while the consultation exercise is going on? I appreciate that you cannot do everything to get people to take ownership prior to making a statement. Networking hospital services sounds grand and it does happen in some trust areas, but this is a big shift of thinking for people in communities. Is there any possibility of the Causeway moving into the control of the Western Health and Social Care Trust? If so, will you have to redraw the boundaries, something about which the population plan could be key?

Mr Compton: Absolutely, you are right, which is why the document contains three options for a particular area and a particular hospital configuration. The options are very straightforward, and I think that everybody knows what they are. Either you take the "as is" position, which is principally an Antrim and Causeway arrangement with a little bit of Altnagelvin, or you say no, Altnagelvin is going to become more influential. As the Minister pointed out, if you roll the clock forward to 2015 or 2016 and look at the services that will be developed on the Altnagelvin site, that option will be important. After all, it is worth bearing in mind that most trauma cases such as fractures and all patients in the area with eye problems or needing dental or maxillofacial services already go to Altnagelvin. This is not a completely new thing; a direction of travel has already been established with Altnagelvin. That is the second option, and you build on that.

The third option focuses on the question of what makes a really successful network between what might be seen as the larger unit and the smaller unit and how to establish a parity of esteem with the clinicians to ensure that they feel properly organised and responded to. The document suggests that perhaps the best way of doing that is to make a transfer. However, these options are for discussion and consideration. No decision has been taken at this point in time.

Urology is an interesting example. About two years ago, we carried out a consultation and moved to three in-patient sites in Northern Ireland. The in-patient site for what is called team north-west is at Altnagelvin, but the actual clinical lead for urology — in other words, the senior clinician who runs team north-west — is based at Causeway Hospital. That is the sort of networking that we are talking about, and there are opportunities to do the same with Antrim. What has been put out to consultation for the population to consider is whether, taking into account all the things that are around, they have any preferred direction, what would make sense to them and what they would feel more comfortable with.

Although we have had very extensive discussions with general practitioners on integrated care pathways and referral patterns, I do not feel that those are particular issues for them; after all, they will refer patients to where the service is provided. What they are concerned about is the speed of access for services for their patient groups, the outcomes and the clinical ability to provide the services. I suspect that general practitioners, particularly in the area in question, want a solution to the fragility that everyone knows exists with regard to the Causeway Hospital.

The Chairperson: Why are A&Es and maternity services not covered in these networking proposals?

Mr Compton: They are. In the section on maternal and child health, the document is quite specific about the future of those services.

The Chairperson: Yes, but there are also local consultations going on within the trusts.

Mr Compton: In some areas. Transforming Your Care is a point in time, but there are things that happened pre-Transforming Your Care and during Transforming Your Care and those are continuing. For example, in the Belfast area, consultation on the future of obstetric services in the Belfast network and at the Mater and the Royal is ongoing. However, what this signals is that in areas where such consultations have not reached that point in the debate they will do so.

The Chairperson: I know that other members want to get in, but I have a final quick question. A number of months ago, there was a big hullabaloo about money being paid to consultants to put

together population plans, and it was suggested at that time that additional money might be needed for the next stages of Transforming Your Care. Where is that sitting?

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): It is still under consideration. No further business case has been settled about a further stage of external support. My clear perspective is that there will be a need for further additional support to implement a change of this extent; after all, this is a very ambitious set of changes, and it will be challenging for existing teams—

The Chairperson: There are no plans in that regard at the minute.

Dr McCormick: There is nothing there yet. There is no tender out at this time, nor are there any clear approvals for further expenditure. However, that is being considered. There is money provided for looking forward on that.

Mr Poots: Given the scale of the work that was involved and the added value in the expertise that was brought to the table and the timelines that they were working to, most of my officials are of the opinion that it was very good value for money, given what was offered to us.

The Chairperson: OK. On the issue of taking people out of the acute residential settings and placing them in the community, I was concerned that the Minister for Social Development had said that, up until now, the Housing Executive had failed to meet its commitments and targets under Bamford. So, although we need others to play their part, I would say, as part of my guarded welcome around that, "Show me what works." When the Minister says that, up until now, the Housing Executive has failed to meet its targets, it creates a wee bit of concern.

Mr Compton: Again, my response to that would be that that is why we are talking about three to five years. Nobody is trying to do anything that is precipitous or difficult for individuals or families. Clearly it is about ensuring that the alternative provision is properly in place before we make decisions about moving away from existing service provision. For example, what has happened heretofore has been happening with the development of housing with care through the Housing Executive and housing associations, and it has also been happening through different types of domiciliary care and greater community involvement. That will continue to be the focus. That is very important. No one wants to get into a position where we are reducing the overall availability and quality of care to individuals.

The Chairperson: I appreciate that, but Bamford was not just yesterday; we have had a number of years of Bamford. My concern is that it is another Department that has to be there to support what we need to do. Is that a priority?

Dr McCormick: Yes, and money was provided for it in the 2010 budget settlement for the Department for Social Development (DSD).

Mr Poots: Over the course of the past year, it has been better placed financially to do it than we have, so we have been saying to the trusts that they have to be keeping up with DSD on the issue, not the other way around. It is not my task to defend DSD, but I think that we have probably been more problematic than it has.

The Chairperson: It just concerns me, if we are talking about that.

Mr McCarthy: Could you outline the mechanisms by which the views and expertise of the full range of allied health professionals will be utilised during the implementation of Transforming Your Care, and can you assure us that there will be appropriate availability of specialities, such as speech and language therapists, including those who are involved in early intervention with children? We must recall that we lost an excellent facility in the ICAN centre in Ballynahinch some time ago. We want to be assured that that care will be provided.

How do you intend to facilitate good workforce planning during the implementation of Transforming Your Care, including training requirements to support the shift to increased community services? Yesterday, the "Belfast Telegraph" reported that nursing staff levels are poor, that nurses' workloads are heavier than ever and that nursing care is being delivered by less-qualified staff. We need assurances that nursing staff levels will definitely be adequate and that nursing staff morale will be maintained as we go forward. We certainly appreciate the excellent work that nurses perform, but unless we do something and look after those nurses, patient care will suffer.

Mr Poots: I will start, and perhaps John will take over.

The decision to close the ICAN centre was taken by the Department of Education. We had a similar issue with Knockmore, where the same thing was happening. The fact of life is that, for speech and language therapists, it is much more convenient to have all the children on one site as opposed to having the speech and language therapists travelling around the country to support children at one school after another, and they can get far more value for money out of the allied health professionals by doing that.

With regard to integrated care partnerships (ICPs) and how they will work, allied health professionals will make their contribution. I will leave John Compton to go into some of the detail on that.

On the second question, we need to be careful with regard to the report in the 'Belfast Telegraph'. The survey was conducted by a trade union, and with the greatest respect and the greatest will in the world, unions do have an agenda, which is fair enough. Fourteen per cent of nurses responded, and 86% of nurses did not respond. I suspect — in fact, I am fairly convinced — that the levels of dissatisfaction are not as high as that particular report might indicate.

With regard to others doing nursing and caring jobs, there has been an upskilling throughout the system, all in all. Nurses now do jobs that doctors previously did, and nursing auxiliaries do jobs that nurses previously did. Safety and effectiveness are the tests here.

If people are doing a job and it is not safe or effective, they should not be doing that job. However, just because a nurse did something 10 years ago, it does not mean that a nursing auxiliary cannot do that job today, provided that it is safe and effective. So the continuous upskilling of our staff will make best use of resources. I do not think that we should view that negatively. Perhaps John would like to comment briefly on ICPs.

Mr Compton: There are a couple of areas that relate to ICPs. First, there was a lot of involvement in the population plans from allied health professionals, who had many opportunities to contribute to the development of those plans. That will continue to be the case.

The Minister has pointed out that integrated care partnerships are a central plank of the whole thing. They give professionals who are working closely with patients and their families much more control over how that happens and where it happens, and more authority and decision-making in the delivery of that care. I believe there will be a very powerful role for occupational therapy, speech and language therapy and physiotherapy in that regard, and they will clearly have the opportunity to be engaged.

The document spells out that we are talking about 17 integrated care partnerships, but it also contains a map that shows the 35 centres of hubs and spokes throughout Northern Ireland where that work will take place. It is about ensuring that the individuals who deliver that care are working in the same premises and the same building, which gives them a much greater opportunity to provide a more joined-up service to those who are receiving it.

Turning to the workforce issue, with regard to nursing, we commissioned services from the providing sector on a ratio of nurses to bed in wards. We are absolutely adamant — and my colleague Mary Hinds, who is the director of nursing, makes it quite clear — that we commission at the standard, and that the ratio of nurses to beds is entirely commensurate with any of the better-performing hospitals in the rest of the UK.

It is also a fact that we probably have in our hospital sector, in proportionate terms, a higher percentage of nurses who are qualified than those who are unqualified. I would be comfortable in saying that there is a good platform for nursing.

You are quite right that we do attend to that and work with it, and that we provide tremendous opportunities for nurses. They are very often the backbone of the entire service. As the Minister said, we now have a whole range of specialist nurses who do things that, 10 years ago, did not happen. For example, if you look at nurses specialising in asthma, diabetes, psychiatry or child psychiatry, there is a whole range of personnel to do that. In order to do that, we must have an active training programme, and an assessment programme to ensure that training takes place. That means a greater clarity of role with regard to who is doing what in a team. It is about a team responding to a group of people; it is not just about individuals responding on an individual basis to everyone who they deal with.

That is clear in the delivery as we make that transition. For example, part of the transitional funding is around enabling shifts in the workforce and enabling training to be part and parcel of ensuring that that happens properly and responsibly.

Mr McCarthy: I am grateful for your response, but I am a bit concerned about the dismissive attitude of the Minister in relation to the unions having an agenda. Of course, we all have an agenda; we are all here for a purpose. We must take this seriously. If we lose the morale of the nursing profession, in whatever capacity, our patients are going to suffer. That is common sense to anyone and every effort should be made to rise above that. I am sure that as change takes place, those who are involved in it are brought along.

Minister, this is the second time that you have blamed the Education Department for doing away with the ICAN centre. The Department of Education had a role to play, but so did the Department of Health. I can remember sitting round a table with the officials — I do not think you were there — and we were almost at an agreement to carry on with that ICAN centre in Ballynahinch, which was a tremendously successful operation, but for whatever reason, it was let go. Where do those youngsters go now? Are they going by default? I think that there was a 75% success rate in the ICAN centre in Ballynahinch.

Mr Poots: I am not aware that they are going by default. The Knockmore provision would probably have picked up quite a number of those children, but a proposal came from the Department of Education on that particular issue to start to disperse physiotherapists to different schools and have centres in six or seven different schools. The physiotherapists, sorry, the speech and language therapists, were able to identify how that would actually reduce the number of sessions that they could give to youngsters with learning disabilities, and our Department strenuously opposed the proposal and pulled them back from that particular situation. I remember the protests about ICAN. Those protests took place just over in Dundonald, at the education and library board headquarters — that is my recollection of it. It was previous to my role as a Minister, in any event, so it may not be worthwhile getting into a circuitous discussion about it.

I do not believe that morale is low amongst nurses. I just came from the Northern Ireland Practice and Education Council conference. I think that many nurses said that they have got a major job to do. I think that many of them said that they are very busy, sometimes too busy, particularly in emergency departments, and so forth, but that is the nature of emergency departments — some days you will be extremely busy, other days you will not be as busy, and that is the way it goes. It is important that we have flexibility when we have departments that are subject to those significant fluctuations, so that nurses in other parts of the hospital can step in to help.

Of course, we will come to times of the year, particularly in the winter periods where the winter pressures are, when nursing staff will come under significantly more pressure. That is the nature of the job. Sometimes, it can get extremely busy, but nonetheless, I think that the vast majority of nurses made a career choice to do the job that they are doing, they enjoy the job that they are doing and they deliver an excellent service for the public. We need to respect nurses for that and we need to have them properly graded for the work that they are doing, but if you are asking nurses to step up and do the kind of work that doctors are doing, do not expect them to do it on the bottom grade. That is not right and it is not appropriate. It does not happen elsewhere, so we should not be abusing our nurses in that respect.

Mr McCarthy: Thank you, I am glad to hear that.

The Chairperson: I do not like having any fighting in this Committee.

Mr McCarthy: That is fine, we were just discussing things.

The Chairperson: I was not blaming you, Kieran. I was blaming the Minister. *[Laughter.]*

Mr Wells: Minister, to go back to the residential homes issue, you have played the cards on the table, and I noticed the headline yesterday that half of the 56 current residential homes in Northern Ireland will close — I wish that the press would not call them care homes because that muddies the waters with nursing homes.

Who has the final decision on that? I know that you have referred it to the five trusts, and the trusts are making their views known to the TYC team as to what happens. Do they refer a list to you or do

you analyse the 56 residential homes and make your own decision? I am just wondering where the responsibility for that decision lies.

Mr Compton: As these tend to be very local services, local commissioning organisations will engage with local providers and local trusts to talk about how best to provide alternatives to residential care for older people. From that a view will emerge as to whether a given facility should or should not close. That will come through the normal protocols, processes and policies that have been established.

On occasion, such decisions go all the way up to the Minister because of a particular issue. On other occasions, those decisions are taken between the commissioning and providing organisations on the ground because they are part and parcel of the outworkings of a change in patterns of behaviour. The local commissioner will work with the local provider and discuss, for example, the population, the assessed need, the number of places needed, how swiftly the number of places can be changed and the implications for this or that facility. As the Minister has pointed out, decisions about facilities with only a very small number of residents are more straightforward; other decisions that might be perceived as very controversial will find themselves going to the Minister.

Dr McCormick: The question in such cases is about who takes the important decisions, and the trite answer is that if the Minister thinks that the decision is important, the Minister has the right to take it. There are criteria, we try to ensure that there are good principles, but there is always an opportunity for particularly controversial matters to be brought to a Minister for consideration. That is just the way it is.

Mr Wells: So if a community has six residential homes, they cannot take the view that three will close and three will stay. Under the criteria that you have outlined, all six could stay or all six could go.

Mr Compton: Yes.

Mr Wells: There is no clarity about what is going to happen, and I presume that we will not get that until the next statement.

Mr Compton: This is a consultative document that indicates that the preferred direction of travel is to move to a position where at least 50% of facilities would close, which suggests that 50% rising to a greater number might close. However, the consultation is the consultation. Anything in the consultation document is a proposal, not a decision; a decision will emerge only after the consultation has closed and a definitive position has been reached.

Certain things are already in train. For example, we have talked about the obstetric unit in Belfast and to some of the trusts with regard to elderly persons' homes. The things in train will follow the normal process throughout this particular process. However, if any new or additional arrangements were proposed or if, say, a local commissioner or provider suddenly decided to close an additional four or five units, that would have to be taken forward after the consultation period. However, those in train will go through the process in the normal way.

Mr Wells: We are talking about only the statutory trust-owned and maintained homes. How many private residential homes are left in Northern Ireland? It is not a particularly large sector, is it?

Mr Compton: One hundred and sixty eight.

Mr Wells: Does that include — is it just residential?

Mr Compton: No, just residential.

Mr Wells: Right. Do you intend to use that sector to take up any problems that might arise from closures?

Mr Compton: Yes. That would be part of it.

Mr Wells: That was helpful.

Moving on to a totally different issue, I know that a few months ago, the Minister was in Banbridge to announce the opening of the new facility there, and that the Portadown one is up and running. In yesterday's statement, you envisaged a network of such facilities throughout Northern Ireland, but there was no indication that the capital funding had been allocated to deliver that.

Mr Poots: No, it has not, which is why we have tasked the health infrastructure board to look at the feasibility of using a non-traditional method for this and we are looking at the involvement of the private sector in developing such facilities in Lisburn and Newry.

We are of the opinion that we do not have the capital funding to move these schemes forward. However, we need to move them forward; we cannot wait forever to deliver them. I know that many members are interested in having these facilities in their own areas. So, to move things forward, I think that someone else will need to build them and we will need to rent them. The money we could save by treating people in the primary care sector rather than the secondary care sector will help to offset that.

Mr Wells: Right. Have you identified the partner for the areas where you have not got —

Mr Poots: No. The process is going on. I will pass that question to John and to Andrew, who chairs the health infrastructure board.

Dr McCormick: The two projects that the Minister has mentioned are still in preparation, but the intention is to initiate a procurement process for identifying bidders and, ultimately, a provider. However, it is important to say that we already have a mixed model of GP premises; some GPs are in trust premises, some are in their own premises and others are in rented accommodation. Significantly, this approach goes strongly with the notion of integration and bringing primary care and trust services together, and there will be a new model to allow for and support the concept of integration and ensure that, in some cases, diagnostics can be accessed on the premises and, in others, that multidisciplinary working can be brought together. We have some good examples across Northern Ireland of where that has been tried, and this is designed to reinforce that and make it more systematic — hence the map in the document showing how this will all look if and when the process is completed. Obviously, we have a long way to go to get to that place, but the model has very compelling strengths and should allow primary care to work better together and better with secondary care and other services. I am sure that John can add to that.

Mr Compton: There will be a procurement exercise for each of these projects that will be open to anyone who wishes to provide a service. It will be a competitive process that will take value for money into account.

The real issue is the model of care. What do we want to happen in these buildings? We want primary care professionals, who provide most of the care to most of us all of the time, to be able to work in one arena and the one building and to be supported by the ability to use technology and have diagnostics to minimise the need for people to go to hospital as frequently as they do. As the document points out, we estimate that, with regard to older people and those with long-term conditions, such an approach will lead to a reduction of about 180 beds in acute hospitals across Northern Ireland. If you look at the number of people who are admitted and then discharged after 24, 36 or 48 hours, you might reasonably ask why they had to go to hospital in the first place. Often they went to get a diagnostic test and to be clear about the treatment that they needed. This approach would do the same thing differently.

Mr Wells: There was a collective sigh of relief in the Southern Health and Social Care Trust area when you announced that all that was really required there was much more of a linkage between Craigavon and Daisy Hill hospitals. Given that a very good relationship already exists between the two hospitals, no one had a problem with that.

However, my understanding is that a buy-in from the Republic will be required to keep the Southern Trust model going steadily forward. In other words, there will have to be an attempt to get more patients coming across from Louth, Cavan, etc, to avail themselves of the services at Daisy Hill. Has that happened or are you able to guarantee that the model will be able to go forward without needing a greater flow of customers from the Republic?

Mr Compton: The issue begins with the network. The population in the whole Craigavon and Newry area is about 300,000, give or take, and the question is how best to organise our hospital services around them. For the past number of years, the two hospitals have been working very closely together and, indeed, have changed how they work and what happens on each site. For example, the surgeons on both sites work across on different rota and support arrangements in both hospitals and some work has been transferred from Craigavon to Daisy Hill and from Daisy Hill to Craigavon. This is

all about dealing with complexity and things that happen in a complicated way, and the approach is working quite well.

It is clear that, locally, the Cooley peninsula just across the border uses Daisy Hill as its local hospital, and we have been in discussions with colleagues in the Republic. The document points out formal arrangements to do two things: first, to have a formal agreement about populations using our hospital services; and, secondly, arrangements for specific services such as the radiotherapy centre in the north-west. So both of those have been agreed at departmental level and political level with colleagues in Dublin, and that is what is in the document. Those words in the document have been through both Departments, if you like. That is part and parcel of the development as we go forward.

A network is not a static thing. The network works well at the moment for Craigavon and Daisy Hill but, undoubtedly, there will be changes, because things will change, treatment methods will change and treatment interventions will change. The point is to get the two hospitals working in such a way that they are flexible enough to respond to those changes, which, therefore, creates stability in the workforce and better outcomes for the population, because people go to the right place for the right treatment.

Mr Wells: Finally, the Committee was down, I think that it was three weeks ago, at the new South West Acute Hospital, which I have to say is the most amazing facility. I also have to say that it looked awfully quiet. It has a fantastic range of equipment — MRI scanners and the whole works — and everything is brand new and modern. However, you might have to do a lot of work to use the asset that you have created there for, in effect, £279 million. You have created a linkage that goes the whole way to Craigavon. Is the idea to try to use the new facility by transferring patients between various hospitals in the Southern and Western Trusts, to keep usage of the hospital up to the optimum?

Mr Compton: It starts from the first premise that we said right away back in Transforming Your Care, which is that, in Northern Ireland, you have to respond to the Northern Ireland population and the issues of the Northern Ireland population. The decision to have the South West Acute Hospital was taken because of the geographical location of the population that lives in that area. I do not think that, because the hospital was quiet, that was necessarily a sign of it not being busy—

Mr Wells: There were a lot of empty beds, John.

Mr Compton: OK, but quietness is generally better than freneticism, if you follow my drift.

It is a fact that we have to network, so we have again been in discussions with colleagues in the South, who have indicated to us that they want to use the facility for certain services. Again, to avoid the South West Acute Hospital stumbling into fragility and difficulty, the sense of a network with Craigavon and Altnagelvin — because it will look both ways — is quite strong and quite profound. That is how you manage those situations. Do not wait until you are in the situation of having fragility because when you are in that situation, it is sometimes much more difficult to get yourself out of it. We know that, and it is important that we have a facility in the south-west, because of the geographical isolation of the population.

Mr Gardiner: Minister, when a family carer reaches pension age, their carers allowance stops, even though they continue to care for the elderly relative involved. This means that the state gets the service for free. Will you assure me that there is no sloughing of the state's responsibilities for care of the elderly on family carers in Transforming Your Care?

Mr Poots: Obviously, a lot of this is around how the Department for Social Development makes out payments. I suppose that some of that relates to what comes from Westminster, in how this is dealt with.

In Transforming Your Care, our vision is to enable people to stay in their own homes for as long as possible, because, first, that is where people like to be and, secondly, that is more cost effective for us. There is a double win to be had there. However, we need to ensure that we provide adequate and appropriate support for individuals in their own homes.

If you have a person who can be described as frail elderly, and who is perhaps supported by another elderly person in the home, we need to be cognisant of the fragility of that situation. In all too many cases, the carer is the one who goes first. We need to ensure, particularly when people are older, that

they receive the appropriate support and that carers go in at the appropriate times and give the kind of support that is needed.

One of the things that Transforming Your Care proposed was to have packages designed for people's needs, as opposed to saying, "This is the one-size-fits-all package. You'll have a carer calling for a relatively short space of time up to four times a day, and that's our contribution to you staying at home."

We need to think smarter about how we do this and how we provide that care and, as I said yesterday, to look at how we can provide more respite care. Respite is absolutely critical to people who are caring; they are under immense pressure. It is not that they want rid of their loved one — far from it — but sometimes they need a few days of rest to recuperate so that they can continue to do what they do.

Mr Gardiner: Thank you for that answer, Minister, but does that mean that if a family member who acts as a carer reaches pension age, they will not get any payment for continuing to look after a relative or loved one?

Mr Poots: That is not my responsibility. I am not deflecting your question; that is simply the situation as it stands.

Mr Gardiner: I think that you will agree with me that the situation is not fair and that they should be treated as human beings; they are still caring for someone who is unable to look after themselves.

What is the proportion of front line staff to administrators in any reduction you plan to make in your efforts to rationalise the health service?

Mr Poots: On your first point, I think that Northern Ireland is different from England in still having a strong family base. It is not always the case, but in many instances, families tend to stay in their local areas and live very close to relatives who need some support and care. I still think that it is right for families to support their loved ones; it is first and foremost a family's responsibility. We as the Government and the state need to ensure that the appropriate levels of intervention are in place to support families in that respect, but it would be a very sad state of affairs if we got to the point where there was an expectation that the state would do it and families did not get involved.

It is estimated that carers save us around £4 billion a year — that is almost the entire health budget. They do absolutely fantastic work, and we need to genuinely appreciate them and ensure that we give them support and, indeed, respite when required. I encourage the member to contribute to the current Who Cares? consultation because his point about the cost of buying services from elsewhere is valid. He might wish to pursue that matter in his response to that consultation.

As for the breakdown between administrative and front line staff, with regard to the 3% reduction that perhaps might be needed, we will need to lose some front line staff. If we lose 180 beds across hospitals, it will make a difference to what is needed in those hospitals. However, we are losing those 180 beds because we are offering the service differently — in any event, that is the vision — and allied health professionals might well move out of hospitals into community settings and nurses will do the same, so I expect that we will need slightly fewer nurses in that situation. However, we will need better qualified nurses, which will mean upskilling and upgrading the nurses involved. Like everything else, it is a case of swings and roundabouts; some of our staff will enjoy benefits, but there will be some downsides.

Mr Brady: I thank the Minister for his very comprehensive statement. On this occasion, I promise not to mention welfare reform and how that might impact on the health service.

Mr Poots: We will be here all night.

Mr Brady: We were certainly there all night last night, and I do not want to repeat that today.

I am delighted that Jim is so interested in Daisy Hill; I think that he was looking for a bit of plague and pestilence around Enniskillen. I thought that it was good that hospital beds were empty in some cases.

In your statement, Minister, you talked about building on the networking between Craigavon and Daisy Hill but with further changes to maximise effectiveness in line with the criteria. On the face of it, that

was optimistic and positive. I know that the link up with the South has been mentioned and that, fortunately, you are being pragmatic about that.

You said yesterday in your statement that you wished that the healthcare professionals would go into the integrated care partnerships and that they would buy-in to that; that was your ideal, what you were looking for. You also said in your statement that it was your wish for healthcare professionals to buy into integrated care partnerships. With regard to Lisburn and Newry, which you have already mentioned, and apart from the logistics of the buildings, etc, have the local healthcare professionals bought into that?

Finally, on residential care homes, which Jim mentioned, a specific case that was raised with John at the patient client council meeting in Newry is illustrative of how many people might be affected. A man in his 80s, whom I know and who is a constituent, had very good family support and stayed at home as long as he could. However, the situation became impossible, so he sold his house and moved into a statutory residential home, which might be one of those under threat. The man's health, outlook and quality of life have all improved, but the problem is that a degree of trauma has set in as a result of the rumour-mongering, scaremongering and fear about which residential homes will stay open. There is really only one statutory residential home in our area, and there is a fear. We might well be discussing savings, transforming care, and so on, but, ultimately, we are talking about the lives of people who have given a lot to society. It was mentioned that there are 168 private residential homes, but in view of the excellent environment that this particular statutory residential home provides, has any thought been given to the private sector maintaining that kind of standard and quality if it takes over those homes? After all, we are moving in that direction and people in residential homes are now seen as a commodity from which profit can be made.

Mr Compton: The short answer is no. Again, this is a proposal. If it emerged as a way forward a little bit down the line, it would go through a process of appropriate and responsible consideration. I do recall the case, I understand the point that has been made and I recognise that social isolation issues might mean that, in some circumstances, residential care is the appropriate solution. The document is not prescribing that there cannot be residential care; it is simply saying that the proportion of it should change, because the whole situation is changing. For example, the number of applications for places in Newry has dropped dramatically, and we are trying to ensure that resources are spent in the right place. The right place to spend resources is in someone's home and then in sheltered accommodation; the spend moves to residential and nursing home accommodation only if that is the proper alternative. No one is going to prescribe that.

With regard to the hospital, the document makes clear that there is a successful network, and one of the reasons for that is that it is very organic and has changed. What has happened between Craigavon and Daisy Hill has changed very dramatically in the past five to 10 years, and all we are saying in the document is that that change will continue to occur. I do not believe that anyone will obstruct or will not want change if it happens in a sensible, orderly way and if they can see benefit from it. Clearly people see benefits from such an approach in both facilities and in the local area. The network is working very successfully and will continue to change and evolve as treatment and intervention and, indeed, demand for various types of services change and evolve.

Mr Poots: In a lot of the residential homes, there has been a non-admission policy for some time, so they are operating well below capacity, with a lot of that capacity being topped up with respite care. We will seek to avoid situations in which although they are settled there, significant numbers of elderly residents have to be moved out of a residential home. We do not want that situation to arise, and we will seek to avoid that.

On the issue of the health clinic in Newry, I make it very clear that we will go after the investment for the city of Newry, but if the GPs are not coming with us, it will go elsewhere. It is as straightforward as that. I will not have a health and care clinic that the GPs are not in, because that will not work as effectively. I absolutely insist on that being the case. I understand that GPs may be on board, and then we hear that they may not be. We need to be clear: we are at the point where the business case is completed, but if we are to do this, that would have to be the situation.

We were lambasted for double-jobbing: Andrew McCormick is the accounting officer and permanent secretary of the Department of Health, Social Services and Public Safety, and he is the chief executive of Health and Social Care. He is also on the health and infrastructure board. I will ask him to put on his health infrastructure board hat. *[Laughter.]*

Mr Gardiner: With one salary. *[Laughter.]*

The Chairperson: And he still looks only 25. *[Laughter.]*

Dr McCormick: That is generous.

Work is ongoing on the preparation of the business case. There are local negotiations going on, but the principle is exactly as the Minister has stated. The point of this and the proposal in Lisburn is to test a new idea, and we want to test it with the best possible option. It is clear that there is a need for better facilities for the trust services. Some of the GPs are in reasonable facilities at present, so I understand the doubt, but, as John said earlier, it is about getting the model of care right and making that work in the local environment. We have a range of experiences, good and bad, from other parts of the region. The clear view is we must get this done on a genuinely integrative basis. We want to work with everybody to make that happen.

Mr Brady: Is there a timeline involved?

Dr McCormick: We are trying to produce the complete business case and get that approved in the next couple of months.

Mr Poots: I would encourage local representatives to apply whatever pressure they can. We would not want the city of Lisburn streaking ahead of the city of Newry on this issue.

Mr Brady: Absolutely not.

Mr Dunne: Thank you very much Minister and panel for coming along today. A lot of issues have been covered. We have talked about the Belfast hospitals. That set-up and the services will be reviewed. Can you elaborate on that? You are saying that the Royal, Belfast City, the Mater and Musgrave will operate as one network, but what will that actually mean for hospital services?

Mr Poots: I will kick off briefly. It is no secret that Belfast City Hospital has been moving towards being a hospital of elective expertise, and will concentrate on elective as opposed to emergency surgery. There is a significant benefit to that, as elective surgery can often be displaced. People have not consumed any food or water the night before, and they are sitting there, prepped for the operation, when all of a sudden someone says, “Sorry, the operation is off because an emergency has come in.” I think that we can manage things better by having Belfast City Hospital as an elective surgery site. Musgrave is very much elective in most instances, as things stand. As our major trauma unit, the Royal would be the hospital to deal with emergency situations for the city of Belfast in the main and with trauma beyond Belfast, for all of Northern Ireland, with the Mater carrying out a course of work.

For things such as ophthalmology services, which have been carried out across three sites, we are looking at one site. Very often, we are looking to do on one site a range of services that have been carried out on two or more sites. That is a course of work that Belfast Trust has been and will continue to be engaged in. Obstetric care is another service that is being looked at. Although there will still be obstetric care at the Mater Hospital, the proposal is to move it to the Royal and to have the midwifery-led unit at the Mater Hospital. All those things are in motion. John might have something to add.

Mr Compton: It comes back to the principle that we are not treating each hospital as an independent entity; rather, the population — and, largely from the district general perspective, the population west of the Lagan — will see the four hospitals operating as if they were one facility and organised as if they were one facility. The document refers to having one emergency surgical centre for that area and that population, and it refers to the Royal site and changes in obstetrics with regard to consultants and its midwifery-led unit.

As the Minister pointed out, for some of the more elective and less emergency situations, although some of them can be emergencies, having services such as ophthalmology all based on one site is a sensible way to organise, and there is a fair degree of support for that. That is not just about the organisation. Importantly, the outcome for patients who need emergency surgery, for example, is better, because you are shifting to a seven-day working arrangement for that emergency surgery service, as opposed to a five-plus-two-days working arrangement, which has been the traditional pattern in many hospitals.

The evidence tells us that if you move to the seven-day, full-on system, the quality and the outcome are much better. For example, on the cath lab situation in the Belfast area, the emergency cath lab will be on one site, it will not be on three or four sites, so the population will go to the one site for that emergency cath lab intervention.

Mr Dunne: Will there be further rationalisation of the management across the sites? Do you see that as part of it?

Mr Compton: If that was required, it would be part of it, of course. As you move through this, there will be ongoing review of whether management is or is not in the right shape. Remember that there has already been a fair bit of rationalisation in the management of the trust in Belfast, so there might be reascription of roles, or different roles might be undertaken by different individuals.

Mr Dunne: OK. I have a few other things. You mentioned the cardiac service in Belfast. Has the cath lab issue in the Ulster Hospital been looked at or is it still under consideration?

Mr Compton: There are two areas of cath lab consideration. One is about what is called the emergency, 24/7, seven-days-a-week cath lab, which affects about 1,000 people a year in Northern Ireland. The decision was taken to have two of those labs, one in Derry and one in Belfast. Numbers determined that, and the outcomes are better that way.

We have a cath lab provision at the moment of about 75 sessions per week across Northern Ireland, and we need to go to 125 to meet the demand fully. This decision is a first-order decision that will take us to about 100 to 105 sessions. When the two labs are up and running seven days a week, we will take a second look, to see how and where what would be described as elective cath lab interventions — more planned interventions — should be located. At that point, consideration will be given to whether that should involve a dispersed model of cath labs — for example, you would have elective sites at somewhere like the Ulster — or whether it would be better to concentrate all the things in one place. To enable us to make that decision, we are going to capture information over the next period of time right across Northern Ireland, so that we have an absolutely solid platform of information to allow us to make the best and most appropriate decision.

Mr Dunne: Just a couple of other things. Minister, you talked about a reduction of 180 acute beds. Anything further about where they might be?

Mr Poots: That is not a plan to cut beds, to save money or reduce something; that is us anticipating that the demand for those 180 beds will not be there, because of the other steps that we take. It is not a matter of us taking beds out of the system and then trying to deal with the circumstances that arise from that; it is a matter of us changing the system and those beds becoming surplus to requirements. At this stage, it is far too early to indicate where might be affected, but we have 10 acute hospitals in Northern Ireland, so you can assume that there will be some impact in every hospital, given that we are planning to deliver better primary care support across Northern Ireland.

Mr Dunne: I will take a bit more convincing. Bed numbers is always a topical issue. It is demand driven. Do you believe that the demand for the beds will fall off eventually?

Mr Poots: That is certainly the desire. It is quite a challenge. Obviously, we have identified the problems in that we have an older population, who suffer from more conditions than others; chronic diseases, which continue to grow; and public health standards that fall far short of how people should be taking care of themselves. All those things will put pressure on beds. However, diabetes, for example, is an area in which we believe that we can do considerably better in dietary issues, and we think that there is more work that we can do on things like respiratory issues. We engage in modern technologies, such as telemedicine, which will, hopefully, avoid the need for people with chronic obstructive pulmonary disease, for example, to come to accident and emergency departments or require admission to hospital.

In the future, we will have a greater level of complexity, higher numbers of people who need care and support and a greater number of problems associated with that. At the same time, we do not have any more money to spend on that. That is why we have to work smarter. If we continue to do things as we do them now, all we will do is ensure that the waiting lists grow, people do not receive care at the appropriate time, the problems will grow and people will lose their lives.

Mr Dunne: We spend roughly £4.6 billion on health. Half of that goes on wages. How can we see more efficiency within the service in order to support those at the front line? There is still a strong feeling out there that nurses and junior doctors are under severe pressure. How can we try to increase efficiencies to increase their ability to operate? How can we, basically, increase their numbers? At the end of the day, if it were not for bank staff and people like that, a lot of the wards

would be under severe pressure and might have to close. If it was not for the use of them, which is relatively expensive, things would be a lot worse.

Mr Poots: It is people's clinical expertise that makes other people better. People who know how to deal with a particular illness, who can prescribe the right drugs and who can engage in all the appropriate activities, including proper diagnoses, are the people who save the lives.

Do they need support? Of course they do. Do they need administrative backup? Yes, that is absolutely the case. I still get the impression from the clinical and nursing staff that they feel that there are too many tiers of management between them and senior management. I try to impress that on the trusts. Most of the trusts are defensive of that situation, but more work can be done, and I will continue to challenge the trusts and tell them that there is still the potential for further efficiencies to be made there.

Far too often, too much is done to cover the trusts' backs, and when something goes wrong and they get challenged, they end up in court. We spend so much time and invest so much money in creating that backup system and demonstrating that every step was taken correctly that we sometimes lose sight of people's real needs, and I always encourage trusts to give further consideration to that matter. I do not know whether my commissioner or permanent secretary colleagues have anything to add on that.

Dr McCormick: We are in only the second year of a four-year comprehensive spending review settlement that makes very significant demands for improved efficiency. The requirement is there, the Minister has made it very clear and the numbers dictate that every effort must be made to find more efficient ways of working. As a result, major changes are being planned for the support systems and the delivery of care to ensure that we deliver very significant additional efficiency savings. That is mandatory.

Of course, it is not the case that, after those four years, everything will be hunky-dory; we know that there is a long-term change in the trend of public finance and that the pressure will continue, so we must ensure that resources are available. There are real requirements for support, some of which arise from public sector obligations and others from aspects of accountability, including, for example, some of the issues that will be discussed at the Public Accounts Committee in a month's time after our report on patient safety comes out.

Handling clinical negligence is a major issue that requires us to be more efficient. That is at the forefront of what John Compton and I are working on now. We are looking at how we ensure that efficiencies and savings are secured and that resources are available for the front line. That includes ensuring that the front line can work effectively and that we are not wasting professional time on things that can be done by support staff. That balance has to be found, and I am wary of having a "Four legs good; two legs bad" syndrome and making some false economy involving front line and support staff.

Mr Compton: In response to the comment that 50% of the health budget goes on salaries, it is very important to understand that a lot of the 50% that is not spent on salaries is spent on direct service provision. For example, when we talk about paying for family practitioner services, we are actually talking about direct provision. We are not necessarily employing staff but we are paying for them through the contact with and access to general practitioners that we as citizens all have. Broadly speaking, I think that 75% goes on direct care and 25% on buying. That is an important footnote.

With ICPs, we know that for the number of admissions in Northern Ireland of people over the age of 75 — I am not picking 75 as an arbitrary age but sometimes older people go to hospital because there is no alternative — the way in which the system is organised, a person who falls repeatedly in their own home will, nine times out of 10, find themselves in hospital; under an ICP, they might find themselves in a nursing home instead. Similarly, someone at the end of life and in a nursing home will be supported to stay in that nursing home; indeed, the Minister recently launched a training package right across the nursing home sector in Northern Ireland for 1,350 people. That is what will result in the 180-bed reduction — people will no longer be using the service as such.

I understand how the man and woman in the street might view management. However, the truth is that you have to manage how you spend £4.6 billion and how you make these changes. You need people for that. As Andrew McCormick indicated, it is not a matter of one group of staff wearing one team shirt and another group wearing another team shirt. Everybody is doing one thing and going in the same direction. At a very practical level, people who arrive at hospital for a surgical procedure expect the theatre to be clean, the goods required to be procured and the staff operating to have been

properly recruited, and so on. The people who ensure that that happens are as much part and parcel of your treatment as the individual who carries out the treatment. Of course, that person has a fundamental position but it all works as one. It is not a case of one thing here and something different over there, and it is important that it is perceived in that way because we have a lot of staff who work extremely hard on these matters.

Mr Dunne: I remain to be convinced about some issues, but we will see. Thank you, Minister.

The Chairperson: You are unconvincible.

Mr Dunne: I do not know, Chair — we will see.

Ms Maeve McLaughlin: I suppose that no one can really challenge the concept behind Transforming Your Care of a move from acute to primary or community care. It is a rational argument, and I hear what you say about shifting processes and managing budgets accordingly. However, the critical aspect of delivering Transforming Your Care will be its tackling of health inequalities, which, in the North and thinking of the three worst constituencies, are very stark and clear. Given that the change is being led very much by the population plans, I am interested in finding out how TYC will target those inequalities and what monitoring processes will give us the outcomes that we need.

The health budget is between £4.3 billion and £4.6 billion. Is there any calculation of how much it will cost to take us from acute to community or primary care? If so, can we see it? Equally, what will the number of people employed by the health service, which I think is about 78,000, look like when TYC is implemented? By how much will that figure be reduced? Before you come back and say that this is not necessarily about numbers of staff but about the quality of service, I have to say that I think it important that we have that information.

I want to finish on two points, the first of which is mental health. Although there has been an increasing, and in one sense positive, move from a medical model to a model for treating the individual, it has come with additional resource demands and requirements. I hope that we are moving away from mental health facilities, but how do we balance all that out?

Finally, I turn to the big issue: early intervention. Last week, we took evidence from the Institute of Public Health in Ireland, which highlighted the impact of, to coin a phrase, invest-to-save processes in Scotland. I believe that it said that £5.4 million was saved as a result of investing in early intervention, and I note that the Education Minister has made a very positive statement about the creation of 20 new nurture units in the North. Increasingly, the view is shifting to that being central, and I think that we are moving to that point, but the advice that we were given last week was that there needs to be preferential targeting of resources to disadvantaged communities. We were also advised that the monitoring and accountability mechanisms were poor.

I know that there is a lot to my questions, but I am interested in hearing your thoughts.

Mr Poots: I will deal with the question on health inequalities. I agree with the member that we need to challenge and tackle that issue and in a way that has not been done heretofore. There needs to be far greater connectivity between Departments. We need to break down the walls that exist between, and sometimes within, Departments. Where officials are being obstructive, we need to move ahead irrespective of that obstructiveness.

I am absolutely clear, and this comes back to the poverty issue, that if we are to address health inequalities, we need to go back to the starting point. There are issues that we have to deal with today because they are on our doorstep today. We cannot ignore youngsters who are in care at 15 years of age, but how do we ensure that there will be fewer youngsters in care a decade from now? How do we ensure that they will have a better chance of leaving school with GCSEs, baccalaureates or whatever the qualification happens to be at that time, that give them an opportunity to go out and get a job rather than ending up in the juvenile justice system simply because the only way that they see of getting the things that other people have is by breaking the law? We need to go right back to stage one to deal with such issues.

How will Transforming Your Care assist with that? For one thing, family nurse partnerships, which deal with very vulnerable parents, will be rolled out across all five trusts. Ms McLaughlin will have experience of those in the Foyle constituency, and I look to members to tell me whether they believe that the programme has been successful in the areas where it has been running. However, the feedback and reports that I get suggest that it is good.

We need to work very closely with the Department of Education through Sure Start and Roots of Empathy and contribute to the proposal announced by the Office of the First Minister and deputy First Minister (OFMDFM) today, which will assist us in helping 1,200 parents. Our director of social care has been pushing very heavily for such a programme for some time, so we are delighted with the news that we will be able to get to more families. The truth is that far too many children are not nurtured properly in the first place, which very often leads to poor relationship development in later years. Far too many children start school without having had any support at home, and so, when they go to school, they do not know how to hold a knife and fork at meal times or sit in their chairs properly. Some children have never been read to, so everything in school seems alien to them. Such children start off school behind; by the time they leave primary school, they are further behind; and, in high school, they just fall behind further. If we are to address those issues, we need to give those children an equal chance, which means starting at the earliest point.

Another point is that the Noble index is now 10 or 12 years old, so we cannot work off that for ever. We need to get the appropriate data if we are to make the appropriate interventions, which may be different in different areas. Therefore, I think that we need to engage in work that will help us to do that. We can also look outside Northern Ireland for potential support in developing the appropriate data to make the proper interventions that will provide us with the right results, because I think that there is an interest in that from beyond Northern Ireland's shores. Again, that requires working across Departments. We need to look at educational outcomes in conjunction with health outcomes, and I think that the Department of Justice has a role to play because, if we do the right things, we will avoid the situation of young people ending up in the justice system. That was a rather long and convoluted answer, but if we want to get better public health outcomes, I believe that we have to start at the very earliest point.

I think that screening for bowel and cervical cancers will make a significant difference to our current expenditure on public health. Those screening exercises have been very successful. We also need to continue working with the general public on lifestyle issues, such as binge drinking, the numbers who continue to be addicted to cigarettes and the obesity brought about by eating too much of the wrong kinds of foods and not taking enough exercise. All those issues will crush the health service if we do not challenge people on where they are and ask them to take a step back. Good healthcare begins at home.

Ms Maeve McLaughlin: Is there likely to be some sort of monitoring process? I hear what you say about the need for good data, which I agree is important. At the meeting last week, the Institute of Public Health highlighted the difficulty of getting robust data, so I think that you are right about that. However, there needs to be some sort of process whereby the outcomes are monitored, so that we ensure that we are constantly reviewing our targeting.

Mr Poots: I happen to think that, in most instances, most parents want to do the right thing for their children, but we should offer help to parents who struggle. Sadly and regrettably, there are a number of parents — a relatively small number but still a number — who, if we do not intervene quickly, will bring great distress to their children, whether through neglect or something else. We need to respond very quickly when we believe that children are in any kind of danger whatsoever. We need those twin prongs.

When I visited integrated care services, which we have ensured will continue in the Shankill and west Belfast areas, I was told the case history of a young woman with five children of primary-school age. Social services had paid an awful lot of attention to her because of the problems that had arisen. After two years, the work of the integrated care services had helped that lady on to a completely different plane: she had managed to deal with her debt problems; she had managed to reach the position where she could provide a stable home; and her children were all attending school regularly. In one area, truancy might be the problem, whereas in another area, there might be a different problem. We need to focus on identifying what the problems are in particular areas and on how we can best help the people in those communities.

I was asked about qualitative monitoring, and, of course, it is essential to monitor the outcomes of any investment that we make. Too often in the past, we have poured money into things, and perhaps salved our consciences, without making the difference that needed to be made.

Ms Brown: I have a few questions. First, can we have an update on the GP networking groups?

Minister, in your statement yesterday, you talked a lot about the Causeway Hospital in the Northern Trust, but I want to ask about Antrim Area Hospital. I know that you stated your dissatisfaction at waiting times for A&E services there. Will you update us on the situation and on whether there are any improvements to come?

On the issue of reducing the need for 180 acute beds, John Compton mentioned that over-75-year-olds are often admitted after a fall, and so on, but I do not think that we have a fracture liaison service (FLS) in each trust area. When are we likely to see that happen? Obviously, I would be very keen to see an FLS in the Northern Trust in the near future. Will the trusts be encouraged to make sure that such a service is available?

Mr Poots: John Compton will deal with the issue of GP partnerships. I will start off on the question about Antrim.

Clearly, there have been problems in Antrim for a very long time, and those problems predate the existence of the current trust. In fairness, the Northern Trust was dealt a pretty bad hand, and it has struggled, to some extent, to get on top of several issues and has been more successful in some aspects than in others. I think that the service delivered in the Antrim Area Hospital is generally pretty good, but we have a problem at the front door. At the hospital front door, a facility set up to deal with 50,000 people now deals with 70,000 people, and that creates pressures.

However, we are developing a new facility and increasing the number of beds, and that capital investment will make a real difference in due course. Perhaps the appointment of 40 permanent nurses came a little late, but at least we are there now. We have a problem with the number of consultants on site, and that needs to be addressed. Some of what has been or is being done will help the situation, but more still needs to be done, and we need to keep the pressure on to ensure that those things happen.

I have made it abundantly clear — I cannot be much clearer — that we are not satisfied with 12-hour waits in general. Antrim has the worst record not just in Northern Ireland but in the UK, and that is not where anyone wants to be. I want waiting times brought down so that 95% of people do not need to wait for more than four hours. We have high expectations, and we will not leave this issue until those expectations are fulfilled. I suppose that Antrim has been the most difficult nut to crack up to this point, but we are not giving up on it. As commissioner, John Compton is working very closely on this issue, and we in the Department are keeping a very close eye on it. That does not always mean beating the Northern Trust with a big stick; sometimes it needs help, and we need to be there to offer support.

There is a course of work to be done, and you are right to point to issues that pose a difficulty in Antrim. At the same time, it is important that the public recognise that they get a good service in many other areas in the hospital. I would like that to be replicated throughout the system.

Perhaps John will pick up on the Antrim issue before he moves on to GP networking.

Mr Compton: We are working on the situation in Antrim. The problem is not fixed, but the 12-hour position has substantially improved since the commencement of the year. Later this month, we will hold an event for all the hospitals — we have also invited representatives from a couple of hospitals in the GB to come across — just to talk about how everyone is getting on with handling the 12-hour arrangements. In general, the situation has not been fixed, but it has improved from the previous period. As the Minister outlined, the capital work that will be completed early next year will give a better capacity — a better footprint or base — to allow the hospital to operate in a more coherent way into next year and beyond.

Work at Antrim is ongoing, with staff going to the hospital, probably once a week, so that they can understand what happens in its systems and processes, how quickly people are seen at its front door and where the delays occur. We are also looking at how quickly people are discharged from the hospital and whether the delays are to do with transport or pharmacy, whatever the diagnostics inside the hospital or other issues are.

People sometimes forget that Antrim hospital is more than the accident and emergency department, so I want to reinforce the point that it does tremendous work in lots of areas. It is very well regarded for the quality of treatment and care that it provides in areas such as cardiology, haematology and renal services. That is not to say that there is not a problem that we should looking at, but having that balance and perspective is quite important.

GPs are a central plank in the whole process of developing integrated care partnerships. There has been extensive discussion with general practitioners and their representatives, and, in the round, I think that we have strong support for what we are doing. Naturally, there are anxieties about whether there will be enough money, and so forth, but there is a complete willingness to work on the issue. That is especially the case in the Northern Trust area, where we have very strong and enthusiastic support among general practitioners.

We have talked about Transforming Your Care and making the shift of 5%, which was calculated at £83 million or thereabouts at that point. I draw the Committee's attention to the fact that £21 million of that is going into family practitioner services to help primary care and support that drive, and £40-odd million will go into community services to support them in driving those services into the future.

I go back to the previous question about inequalities. Integrated care partnerships are at the core of this. We know that 60% to 70% of people who present from highly deprived areas do so with certain clinical conditions. Integrated care partnerships will be a very profound vehicle to deal with secondary prevention, which involves arresting the difficulty of conditions such as chronic obstructive pulmonary disease (COPD), which is clearly linked to deprived areas. If you come from a deprived area, you are 60% more likely to have COPD. That approach is a way of handling that.

There will also be work with local communities in the whole area of prevention and early primary prevention. That will be measured, as we will talk to the 17 partnerships about the activity that they will have to handle.

I will restate what I said earlier about the Causeway Hospital. The proposal is about what is the best way forward for the network. There are some decisions to be made, and the question in the consultation to the population of that area is, "What is your opinion about doing it this way or that way?" We will consider what is said at a future point.

Ms Brown: We would not want any more people coming to the door, certainly not in A&E. I agree absolutely with you that the hospital is superb. Unfortunately, headline figures create a perception, which we want to dismiss. I am really glad to hear that Antrim is still a very high priority and that the Minister is not giving up on it. That is a great comfort.

Mr McDevitt: I am sorry that I was delayed.

Minister, will you clarify something for me? Did your statement yesterday guarantee a future for all our existing acute hospitals?

Mr Poots: Yes.

Mr McDevitt: OK. So we have good news in the sense that there is a future for all of them, but what they do will change. As I read it, it is about patients being able to go to one place and be assured that their pathway will be taken care of in that place. Given that, what expectations will there be on clinicians to be much more mobile and responsive than they are today?

Mr Poots: We would like to see that. The integrated care partnerships allow that discussion to take place. On occasions, if we are doing more work in the community, it will be more suitable for clinicians to deliver services in the community or in primary care settings.

One particular area in which that will be addressed is mental health services. That type of support may very well be better provided in primary community care settings than in secondary care settings.

There can be no Holy Grail. Clinicians cannot work exclusively in a hospital setting and expect everyone to come to that setting at all times. The shift left does involve clinicians.

Mr McDevitt: Thinking about clinical mobility and bringing it back to a subject that we have debated for some weeks — paediatric congenital cardiac services (PCCS) — do you envisage greater mobility on the island and an opportunity for all-island specialist networks to emerge? Is that consistent with Transforming Your Care and the direction of travel?

Mr Poots: Having a smaller population makes sustaining certain services more difficult, so we have to link with other populations. On this occasion, I have stated my preference for the linkage to be with

the population in the Republic of Ireland, as opposed to Scotland or the north-west of England. For other services, the situation may be different.
The discussions on PCCS are ongoing, but we will insist on achieving the best possible standards for people, irrespective of where that happens. There is always a debate between locality and speciality. Everybody wants a speciality, but they want it to be as local as possible, and it is always difficult to square that circle. It is no less difficult in this particular case.

Mr McDevitt: You could see how, if it worked well, the model might offer hope for other patient groups, particularly those suffering from rare conditions, who find it a great struggle to access services.

Mr Poots: Absolutely. Rare conditions pose a major problem for us, but I suspect that, in some instances, we will be able to resolve it only on a British Isles basis. Indeed, some conditions are very unusual, even among a population of 60 million. Nevertheless, I agree with you.

Mr McDevitt: Semi-rare conditions might just fit into a population of eight million.

Mr Poots: Yes. It is all about scale. I have no issue with such matters being taken forward in London, if that is the best place to do it; or Dublin, if that is the best place to do it; or Belfast, if that is the best place to do it.

Mr McDevitt: I listened very carefully to Ms Brown's comments, and I agree that we need to be very careful to acknowledge the limitations on the infrastructure at Antrim Area Hospital. However, the Northern Health and Social Care Trust does not seem to be able to escape certain issues. This might be a question for all three of you: are you satisfied that the Northern Trust's management is on top of that trust's issues?

Mr Poots: It is important that we continue to work with the Northern Trust and give it every opportunity to get on top, and stay on top, of all the problems. As I said, these are historical problems that came from the old trust. I think that, at this stage, what the Northern Trust needs most is a supportive, and sometimes critical, friend, and John Compton and the Health and Social Care Board team are often up with the Northern Trust, seeking to ensure that that is the case.

The Chairperson: We do not need the three of you to answer that question. The lead singer has already answered it.

Mr McDevitt: Fine — you are the Chair.

Mr McCallister: I have a couple of questions, Minister. On the issue of early intervention, which Maeve McLaughlin led off with, everyone supports the approach that you are taking. However, we need to get to a point where one department, the Health Department, I presume, truly champions the issue. A lot of Departments are talking about it and looking at strategies, but we never seem to get anything in place. The Department of Education, for example, has looked at a 0 to 6 strategy, but has no real interaction in a child's first three years. OFMDFM also has some strategies on early intervention. Would it be helpful for your colleagues in the Executive to say, "Right, Edwin, you lead on this and we will help with the funding"? I entirely agree with your comments and with the hope that, a decade from now, far fewer children will be in care, and outcomes will be exponentially better. However, I am never quite convinced by how we get all the ducks in a row and reach that position.

Mr Poots: Certainly, the early years sector would like early intervention to be taken forward by one Department. I am not saying that it should be the Health Department. Perhaps there needs to be an overarching approach through OFMDFM, or perhaps my Department or the Department of Education should take the lead. However, I am not prepared to engage in horse trading over the matter.

We need to identify the best way forward, and then we all have to step up to the mark. If that means that a Department has to lose some services, so be it. If it means that a Department has to take on more responsibilities, it will have to take them on. As the Department with the largest budget, we are not particularly anxious to take on more responsibilities. However, if the widespread perception were to be that early years would be best dealt with through this Department, neither would we shirk our responsibility. If that debate is to be had, I want all of us in the Executive to look at the matter in a mature way and identify the best way forward, irrespective of whether a Department will be affected in the form of greater burdens or fewer services.

Mr McCallister: Would we be able to bring in other community groups such as Home-Start, which has done good work in this area? I recall that we visited a Home-Start project in, I think, Newry, and, in my constituency, Jim Wells and I have seen similar projects in Ballynahinch and Kilkeel. How do we tie all that in with the clear direction that you want to go in and get buy-in from the people who deliver services on the ground?

Mr Poots: Sometimes, I think that there are too many initiatives going on at the same time and that they are not well enough connected. If family nurse partnerships are going on at the same time as Sure Start, Home-Start, Roots of Empathy, and so on, and there are other areas with integrated services, the question is how we ensure that the right hand knows what the left hand is doing. In that respect, it would be better for all such initiatives to fall under one Department. At least there would be one team of people identifying all the work going on, ensuring that we got good value for money and that the services being delivered were connected, and making sure that there was no disconnect.

That is important but, of course, another important issue is how we fund these initiatives. I think that the Department of Education has been reasonably generous in its funding of Sure Start and have no criticism to make of it on that front. However, there are other opportunities that we really need to get our teeth into, on which we need to work cross-departmentally and in which the Public Health Agency is very keen to get involved. The reciprocation could be better — I am not saying that at a political level.

The Chairperson: In our conversation this afternoon, Minister, we have talked about a vision for the future and how TYC might take anything from three to five years to implement. Indeed, depending on certain issues, it may take longer. If it becomes a reality, do you have any idea how much Health and Social Care will cost, maybe in five years' time?

Mr Poots: A bit more than it costs today.

The Chairperson: Yes, but with better outcomes?

Mr Poots: I suppose that the problem is this: when Andrew McCormick goes over to London, he is told that he will be getting less money. To be perfectly honest, the budget has largely flatlined. We are not operating with less money, but our costs are not flatlining. New drugs, for example, cost more money. Those costs might be offset to some extent by branded drugs becoming generic, but staff costs are also going up. After all, we cannot have pay freezes for ever, and we must recognise that the cost of living is rising. Therein lies our difficult problem: although we are living on the same amount of money, many of our costs, as well as the demand for services, are going up. That is why TYC is absolutely necessary. However, I think that I can safely say that, in five years' time, we will be spending somewhere between £4.5 billion and £5 billion.

The Chairperson: We have had a useful discussion this afternoon. Minister. I know that you are scheduled to come back in a couple of months' time to talk about the next stage of TYC. Thank you for your presentation, Minister. It was a pleasure as always, gentlemen.