Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Transforming Your Care: Trade Union Briefing

5 June 2013

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)
Mr Roy Beggs
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr Conall McDevitt

Witnesses:

Ms Maura McKenna	Health and Social Care Trade Unions
Mr Kevin McCabe	Northern Ireland Public Service Alliance
Ms Patricia McKeown	UNISON
Mr Jonathan Swallow	UNISON
Mr Kevin McAdam	Unite

The Chairperson: Welcome, guys. We were a wee bit quicker with an earlier session than we thought we would be. I know that we gave you a time to attend, so, for the record, it is not your fault. Things simply went more quickly than anticipated.

Ms Patricia McKeown (UNISON): Sorry about that. We were across the road in the Stormont Hotel having a pre-meeting, so we could have been here.

The Chairperson: We need one of those red telephones.

For witnesses' information, I point out that on 15 May, the Committee agreed to undertake work to look more closely at the implementation of Transforming Your Care (TYC). The strategic implementation plan is being updated to reflect the conclusions of the public consultation, and it was expected to be completed by the end of May. The Committee is beginning its work with this formal meeting. We had an informal meeting with the unions a number of weeks ago, and today's meeting is a formal briefing from the unions on their concerns relating to TYC. Next week, we will have a briefing from the TYC implementation team on the implementation plan. We have a session scheduled with the Minister on 5 July on Transforming Your Care, and we will use that opportunity to raise our concerns about the implementation process. After the summer recess, the Committee will begin to scrutinise the various themes of Transforming Your Care, such as older people, learning disability, maternity care, and so on.

You were not present earlier, but for future reference, we were sent a paper yesterday from the Department on some legislation. The paper arrived on our table today, and I have told the Department that we will not take that item of business today because we, as a Committee, need time to look at papers. For future reference, I encourage you to try to get papers to us sooner rather than later — Maura, I am not even looking at you *[Laughter.]* — because some of us sit on other Committees, and we need time to go over any papers. It is important that members get the opportunity to familiarise themselves with the issues that the public and witnesses — not just you specifically — want to raise. Nobody would disagree that this is important work, and we need you, as representatives of the unions, to be key stakeholders and work with the Committee.

I assume that you are taking the lead, Patricia, so I will hand over to you in a moment. For us to get as much as possible out of this session — it is a formal setting — members have a number of questions that we will come to after your presentation. May we try to keep it as succinct as possible? Rather than everybody answering at once, work out among yourselves who will answer what so that you leave here in an hour or an hour and half having given us as much information as possible.

Do members have any interests to declare before the session formally begins?

Mr McDevitt: I am a member of Amicus.

Mr Brady: I am a member of the Services, Industrial, Professional and Technical Union (SIPTU).

The Chairperson: I think that I am a SIPTU member, but I have not paid this year's dues.

Ms P Bradley: I am a member of UNISON.

Ms McKeown: Good for you, girl. Did you hear that?

The Chairperson: You are not asking any questions. *[Laughter.]* How did that get through the party? *[Laughter.]* Any other members —

Ms P Bradley: I was 18 years old, Chair.

The Chairperson: That was three years ago. *[Laughter.]* Do any other members need to declare an interest? Kieran, are you a member of any union?

Mr McCarthy: I used to be, but I am not any longer.

Mr Wells: I was a member of the National Union of Students 40 years ago.

The Chairperson: You need to declare that.

Patricia, you are more than welcome. It is good to see you here today. You have brought the sun with you. I hope that it is still sunny, and not raining, when you are leaving.

Ms McKeown: Apologies if it looks as though we inundated you with papers. We will describe what these are. They are not just as overwhelming as you might think. Maura, via the trade union side negotiating body, submitted a range of final responses to Transforming Your Care from the various health organisations; those are probably all dated January 2013. Those papers were submitted to provide background information and to demonstrate that there is a very large measure of agreement across the various organisations on the key issues. They were also submitted because, when the Minister made his final announcements about Transforming Your Care and spoke about the consultation process, all trade union responses were omitted. We thought that it was important to —

The Chairperson: Sorry, Patricia. We are not for one minute objecting to new information coming to us; there is not a chance of that. It is useful for us to get that information. We are asking that, in future, you try to get it to us a bit earlier to allow us to prepare. Keep the information coming.

Ms McKeown: No problem.

The other information that we sent is the same documentation that we gave you when we met you in informal session about a month ago. We thought that we had better reissue that, so we are not, in fact, submitting anything new. However, a number of things have happened since we met.

I want to talk about two key areas: first, the way in which decisions are made about our health service and its future; and secondly, our extreme concern that we are looking at an exercise that is not what it seems and that, effectively, Transforming Your Care is the report from McKinsey and Company dressed up in new clothes. Those clothes are aspirational about the kind of health service that we should have. We all subscribe to the aspiration for a decent system of public health that is delivered as locally as possible and so on.

When the Minister says that 97% of the people of Northern Ireland have signed up to this, he actually means, as you will see from the consultation response report, that people have signed up to the vision that we need change in our health and social care system. All bar 3% of the population, including us, think that we need change. However, it is taken for granted that that also means that 97% of the population have signed up to this model of Transforming Your Care. In fact, as you will see from the trade union responses, we definitely have not.

There is a great difference between the aspiration and the actual implementation plans. We say that the implementation plans are predicated very deeply on privatisation of the National Health Service (NHS). Our Government have not made statements, like the Scottish Government and Welsh Government have made, that the National Health Service will be protected, its principles will be upheld, it will be free at the point of use, and it will be delivered by the public service. That is the commitment in those two jurisdictions, and we want it in our jurisdiction. So, right away, we get nervous when we see a proposal such as 'Transforming Your Care' that mentions the principles of the NHS but does not incorporate those into any of the outworkings of the document.

The privatisation element affects all aspects of the healthcare system. There is privatisation of medical treatment itself. There has been a 10% increase in the use of the NHS by private patients with private insurance, which could have been achieved only by the displacement of existing NHS patients. We know that they have been displaced. We know that they have gone to Mullingar, to the private sector here in the North, and they have gone elsewhere including, primarily, England and Scotland.

The privatisation of residential care hit the headlines recently. There are only 39 NHS residential care homes left in the system. Belfast is almost bereft of them, but the Northern Health and Social Care Trust, for example, retained its NHS homes to a large extent. That was a good thing, but it is now being interpreted as a bad thing. The chief finance officer — or whatever his formal title is — of the Health and Social Care Board (HSCB) is on record as saying that, if the Northern Trust wants to sort out its financial problems, it should extricate itself from its residential and domiciliary care systems. That is very disturbing because, in the very detailed studies that my union has been involved in, in partnership with the health service, the Department of Health, Social Services and Public Safety (DHSSPS), the trusts and the private and voluntary sector, the NHS has come out on top every time in the delivery of residential care. Indeed, the whole point of the exercise was to raise the level of care in the private and voluntary sector to the same standard as NHS care. We have not done that yet, as you will see from today's headlines.

The Committee needs to pay particular attention to the claim that there is a reprieve. There is no reprieve. The Minister, in his statement to the Assembly, stopped the current process but, in his next sentence, restarted it by closing the doors of the homes to new people. One home — in Carrickfergus, I think — has four residents left. Those residents are in a room waiting for the end of their lives. They will not stay there until there is only one standing. That home will close. A range of homes are scheduled to physically close within the next few months, no matter what statement was made to the Assembly. The doors have now been closed to long-term care, even though they could take that care, and to respite care.

There is a growing body of evidence about this. We have been holding meetings across the areas of the 39 homes since we last met you four weeks ago. Those meetings were attended in large part by the residents and their families. We now have chapter and verse on people who are in desperate need of respite care and longer-term residential care being turned down by the NHS. We have asked those people to approach you, as the scrutiny Committee. We have also guided them towards the public meetings of the trusts in their areas and the public meetings of the Health and Social Care Board. It is time that somebody met them face to face and listened to the truth. I find those meetings very distressing. There have been many tears and a great deal of anxiety and distress among all the

people involved. There have also been some wonderful stories about the level of care that people receive.

The withdrawal of NHS domiciliary care is also a major part of the transfer from the health service to the private sector. The contractual standards that we operate under in the NHS are not there in private sector residential and domiciliary care. We have seen the documentation and can guarantee that the standards are not there. That is very disturbing. The absence of those standards leads to the kind of issue that hit the headlines today. The records of the Regulation and Quality Improvement Authority (RQIA) and the level of complaints that have been lodged against residential or domiciliary NHS care vis-à-vis private and voluntary sector care show that there is no comparison. The vast majority of complaints are about the private and voluntary sector.

The transfer of domiciliary care is happening rapidly. We know that from senior people in the trusts, who have not gone on the record formally. I am urging them to go on the record because second-hand information is not good enough. They tell us that the commissioner is insisting that all new referrals for domiciliary care should go into the private sector in one form or another, either directly into the sector or by being offered direct payments. We already have an admission from the chief executive of the Health and Social Care Board that the direct payment system is in turmoil.

I have recently been dealing with the case of a family whose mother had been encouraged to take direct payments by a health trust. She did so; she ended up needing 24-hour care and three different carers, and she died. The family has received a £6,500 redundancy payment bill. That is the reality of direct payments. In that trust, I noted that less than 50% of the people from whom it gets direct payments are clients for whom direct payments were constructed: namely, adults with physical and mental disability issues to allow them to live independently at home. More than 50% of its direct payments come from older people. Those older people are supposedly the employers.

The final element of privatisation that is moving apace is the use of private finance to build or rebuild parts of our health service. There was a recent announcement about the centres in Newry and Lisburn. When we met you, we said that we wanted to see the business case and were sure that you would also want to see it before we could pronounce in detail about those issues. The shocking thing is that we have been told officially that there will be no business case, and the fact that it is a ministerial decision overrides the need for a business case. I have never heard of such a thing. I never heard that under direct rule, and this is the first time that I have heard of such a thing during the time of the Assembly. That is profoundly disturbing. The union movement has been told that, and the same information has been conveyed to the Public Health Agency (PHA), so there has to be some measure of truth behind it. I hope that the Committee can intervene at a very early stage, because we are hearing rumours of a potential bidding process. It is unconscionable that we could be so far down the line on anything such as this with no business case, no Treasury guidance applied and no green book test — all the things that we would expect.

Those are the core issues from our concerns on Transforming Your Care. There is a vision that we all sign up to, but there is a model that will not deliver that vision and will deliver the opposite. Instead of paying attention to the increasingly difficult problem of challenging health inequalities in our society, all the signs are that it will deepen them. That is our overview. A great deal of the evidence behind what we say is contained in the documentation. We want to back that up with more proof, which we will be happy to offer the Committee.

We have invested an enormous amount of time and effort into genuinely analysing all the work that is coming in our direction via trusts, the Health and Social Care Board and the Department of Health. We are not looking at this dogmatically and saying that we believe in a certain idea and dismiss any other ideas. We are dealing with the facts that are being placed before us in the documentation and our own analysis and knowledge of what is happening in other healthcare systems. Jonathan, have I left anything out that you think needs to be flagged to the Committee?

Mr Jonathan Swallow (UNISON): There is a link between the processes of privatisation in residential and domiciliary care and the ongoing march of private medicine into the sector. We are seeing domiciliary care workers on contracts issued by trusts being paid less than the minimum wage as defined by HMRC, and no one is taking any responsibility for that.

The Chairperson: Thanks for that overview. As I said at the start, this is major work for the Committee. It is important that, as unions, you are the key stakeholders in every phase of the journey in Transforming Your Care. It is important that, as unions, you work with us on these issues.

Patricia, you said that you were told officially that there will be no business case for the centres in Newry and Lisburn. Who told you that?

Mr Swallow: Senior officers in health estates.

The Chairperson: When was that?

Mr Swallow: About three weeks ago.

The Chairperson: The reason why I ask is that we have written to the Minister and are still waiting for a response.

Mr Swallow: I will draw a contrast with the Enniskillen hospital. Six months earlier in the process, the business case had been disclosed in accordance with Treasury guidelines, we had made our comments and were making our inputs into the competitive dialogue tendering process. In this process, there is silence and no response.

The Chairperson: You are telling me that you were officially told three weeks ago that there would be no business case.

Ms McKeown: Yes. The same information was given to the board of the Public Health Agency. We have a trade union nominee on the agency.

The Chairperson: Was that at the same time?

Ms McKeown: Yes, roughly at the same time.

The Chairperson: Was it at a Public Health Agency meeting?

Ms McKeown: Yes.

The Chairperson: You are right about direct payments because I deal with those issues in my constituency. Did you say that the chief executive of the board said that the system was in turmoil?

Ms McKeown: Yes. On more than one occasion, we challenged John Compton. We challenged him directly in a meeting with all the health unions and the professional organisations in Linenhall Street at which he admitted that there were problems. We also challenged him at the beginning of December at the first of the public meetings on Transforming Your Care at which he described it as being —

The Chairperson: Were those meetings minuted, Patricia?

Ms McKeown: I imagine that he had people taking notes at the public meeting.

The Chairperson: What about the meeting in Linenhall Street?

Mr Swallow: I have a note from a meeting of the Northern Ireland Confederation for Health and Social Services (NICON) last October when the chief executive of the Health and Social Care Board said that the system was effectively busted.

Ms McKeown: We think that that was televised.

The Chairperson: When you talk about "the commissioner", I assume that you are talking about the chair of the board.

Ms McKeown: The chief executive — John Compton.

The Chairperson: Sorry, the chief executive. You say that that person is insisting that, when it comes to domiciliary care, people need to go straight into the private sector. Is there a record of that being said?

Ms McKeown: We are seeing the practice, and senior people — in the Belfast Health and Social Care Trust, for example, at a very senior level — tell us across the table that they are under instructions that all new referrals will go into the private sector. The problem is that they are not prepared to say that beyond the confines of that room. I need a whistle-blower.

Mr Swallow: The recent document on residential care from the Northern Trust explicitly states that all future referrals to domiciliary care will be to the private and voluntary sector and that that will happen in the context of any member of staff leaving in-house.

The Chairperson: I repeat: this is the start of us looking into the situation, so it is useful to have that information. What is your view on integrated care partnerships (ICPs)?

Mr Swallow: Last October, we were promised a paper on their governance. There has been no paper, in our understanding, on their governance. Work is clearly proceeding in that the central services agency, the Business Services Organisation (BSO), recently advertised for a leadership training consultancy for integrated care partnerships. However, as to a piece of paper that states in detail how they are governed, who is on them, what their obligations are to the Department, the board and anybody else and the extent to which their employees are NHS staff, that remains an ongoing mystery.

Mr Kevin McAdam (Unite): There is a reference in 'Transforming Your Care' to a strong collaboration with independent healthcare providers that, in my view, is a direct link to using ICPs as a vehicle towards privatisation.

The Chairperson: I am going to open the meeting up to other members. It sometimes seems that I am jumping from one issue to another, but I am trying to tease out more information. Your paper refers to recent attempts by health estates to reverse the policy of the previous Executive to exclude soft services from PFI schemes. Is there evidence —

Ms McKeown: Yes. There have been three years of formal negotiations with the Minister and the Department of Health: the removal of all soft services from the South West Acute Hospital contract and a clear commitment that that would be the pattern should there be further such forms of procurement. It was actually secured with direct rule as well as copper-fastening it with —

The Chairperson: Are you saying that health estates are trying to reverse that?

Ms McKeown: Yes — but not health estates. We think that it is a ministerial decision.

The Chairperson: It says health estates in your paper.

Mr Swallow: The statement that we had is that the Executive have accepted the PF2 model as set out by George Osborne in the last Budget. In that model, soft services are excluded and are not part of the deal. Therefore, we have historic Executive policy that says that, we have apparent statements accepting the PF2 model, yet we have a consistent statement at various levels of bureaucracy that the Minister wishes there to be a value-for-money test.

Ms McKeown: A value-for-money test flies in the face of the first Assembly mandate, when the first half of the — *[Inaudible.]* — instructed that there should be equality impact assessments of services, both in-house and outsourced support services, which are described as soft services for that purpose. That demonstrated a failing in quality and equality for outsourced services. It was a period of some seven years, but eventually all services came back in-house in the health service as being the best way to deliver better-quality services and better treatment. The first Administration took clear action to protect, and the second Administration took clear action to exclude from privatisation again. It would have meant that people would have been faced with going straight back in again, which is copper-fastened by existing government policy on any attempt to reverse that.

In the past, unions were involved in value-for-money exercises for services in health. They were directly involved in the terms of reference and the process. The workforce was part of the exercise and was given clear evidence on a range of issues.

The Chairperson: I want to follow up on that, and then I will open up the meeting to members if they indicate that they want to ask a question. Do you think that the soft services in Newry and Lisburn are a target?

Ms McKeown: Yes, we have no doubt about that.

Mr McDevitt: I apologise to colleagues and guests that I have to leave soon. I have a question for Patricia and Jonathan that relates to the UNISON submission. Paragraph 7.2 of your submission states:

> *"The personalisation principle is obvious: all should receive the care that meets their personal needs and aspirations. The contradiction and logical flaw in TYC is the assumption that this automatically means diversity of providers."*

Will you explain that to me?

Ms McKeown: There is a clear assumption throughout that in order to provide that diversity, we will move into the private and voluntary sector. I suppose that that diversity will come from existing NHS services in which we have award-winning domiciliary and residential care services, and various forms of initiatives and developments being undertaken. Quite a few have been in partnership with us to see how we can deliver those services better. That is not the interpretation, however, because were it so, the doors of the 39 NHS residential homes would not be closed to new people nor would we have this clear and determined agenda of transferring all future home care into the private sector.

Mr Swallow: The extent of the dogma is such that the Health and Social Care Board recently selected six projects that are with the voluntary sector at grant levels of around £30,000 and put them out to competitive tender.

It is de minimis — it is not effective — to go through enormous sets of documents and competitive tendering processes for services for which you are giving a grant of £30,000; either you get them to deliver it, or if they do not, you go somewhere else. This diversity and personalisation agenda has now reached the ludicrous level of a small organisation in Cookstown discovering that it was going to tender for a grant of £30,000 a year.

Mr McDevitt: My understanding of the personalisation principle — the idea of care being built around an individual citizen — is that the decisions would be clinical decisions. What evidence can you point to that says that you do not adopt a clinical approach but a business or financial approach?

Mr Swallow: The direct payments problem has shown that clinical need has been overridden by a policy commitment. There is a simple clinical judgement. The failure here is that in-house NHS services have shown enormous capacity to adopt change and to personalise what they do. To simply lay that aside because of what we are calling the dogma that diversity of provision must be personal is fundamentally mistaken.

Ms McKeown: Evidence can also be found in the delivery plans, which is where the sums are. We already know the size of the gap in funding that is necessary to deliver our residential and social care to the standards that we would expect — the Marmot standards, if you like — but we also know the allocation of money in the trusts' budgets and the plans for a reduction in those services.

We can go as far as to say that the evidence exists on the number of hours and the number of jobs in either the NHS or the private sector that are delivering. The pattern clearly shows a stark increase in hours and jobs in the private sector as opposed to the NHS, where jobs are being lost.

Mr McDevitt: I have one last question about the Lisburn and Newry pilots. You are very sceptical about those pilots, and you talk about them as being "back to the future" in their use of private finance initiatives. Your submission also refers to extensive findings by the Public Accounts Committees here and at Westminster on PFIs. Do you want to bring any of those reports to our attention right now?

Ms McKeown: All of them, from the report on the car park at the Royal Victoria Hospital, where the National Health Service could have been making a bleeding fortune if it had built the car park itself and kept the money coming into the coffers to develop the health service, to the findings of this Assembly's Public Accounts Committee on the three pilot PFI schools, including the refinancing and the very large

profit being pocketed by the private developer, to the studies in England, the Public Accounts Committee findings and the fact that such a large number of NHS trusts in England are now bankrupt, the sole cause of which has been paying the PFI bill.

We have also pointed out to you that we brought the facts and figures to the then direct rule Minister and the permanent secretary in the Health Department on the proposals for the new hospital in the south-west, which did not meet the green book criteria and did not stack up financially. Apparently, there had to be a flagship PFI, and the hospital in the south-west was it. The Strategic Investment Board ploughed ahead and built the hospital. Today, the budgets of all five trusts are top-sliced to pay the mortgage. Obviously, there is also a payment coming from the Department of Health, Social Services and Public Safety, otherwise the entire Western Trust would go under. There would not be money left to cover the healthcare needs of the population of the west. That is the consequence of one PFI in our system. It was thought that there would be a proliferation of many PFI projects — at one point, it was suggested that there would be 16 — although we think that there might be some rollback going on from that. We think that evidence is emerging that the doctors are not keen on this model, so that is all the more reason to get our hands on the business cases.

Mr Kevin McCabe (Northern Ireland Public Service Alliance): I am glad that you raised the issue of personal care, because, in NIPSA's submission, we say that there is no real choice for older people in the current HSC system. Currently, the system places more emphasis on personal care than on social care, and personal care with critical needs is a medical functional model, which is financially-led as opposed to needs-led. As a consequence, the social care element has been negated and lost because it does not take a holistic approach. So, our concern is that older people with social needs will slip through the net and are a soft target. We are very clear that the model currently presented is, as I said, medical functional as opposed to needs-led.

Mr Gardiner: Thank you, Patricia. I must submit to your wealth of knowledge. Have you any reliable figures that tell us how expensive it is to run a publicly owned care home in comparison with a privately run care home?

Ms McKeown: It depends on whether you are exploiting your staff and your residents or whether you are treating your staff properly and giving your residents quality of care. There are figures.

Mr Gardiner: I would want it both ways.

The Chairperson: To add to Sam's valid question: in a sense, the general figure should be based on how much we pay for a statutory resident and how much we pay for a private resident.

Mr Swallow: The Health and Social Care Board, as its predecessor did, maintains the figures on the annual tariff negotiation for a private residential care home, so there is a tariff per resident. I have never seen any great distinction between that and the residential costs, and nobody has put forward the argument that the residential care public model is more expensive.

Mr Gardiner: Are you telling me that you do not know?

Mr Swallow: Effectively, the budgets for public homes are set in accordance with the tariff as well.

Ms McKeown: No, we do know. We are saying that those are the figures that are available. On the question of how much further work has been done by the Department of Health, Social Services and Public Safety, I do not think that there has been.

Mr McCabe: On that, I will give the Committee some further food for thought. The general running costs of residential care homes is relatively low in the context of the budget.

Mr Gardiner: Are you speaking about private or public care homes?

Mr McCabe: I am speaking about homes run by the statutory sector. I have a case in point for if this policy is rolled out and residential care homes go to the independent sector. In the case of Peacehaven, the RQIA came in and said that it was not fit for purpose and made quite a number of significant recommendations. Its independent owner did not have the resources to fund the RQIA changes, and, as a consequence, the Southern Trust had to step in to rescue the clients who were in

that setting. If you close the statutory residential homes, how would you deal with a Southern Cross scenario, were that to reoccur? That has to be set in the context of —

Mr Gardiner: Yes, but have you any figure for how much that is costing?

Mr McCabe: We can certainly provide that information. I do not have it to hand.

Mr Gardiner: I would appreciate that for a comparison.

Mr McAdam: One of the issues with Transforming Your Care is that, when John Compton was asked about the costs of residential care homes, his only argument was that there is no need for them. He has never put forward a financial argument to say that it is cheaper in the private sector, so those figures have never come from the management.

Mr Gardiner: Maybe we should send it further up the line.

Mr McAdam: Absolutely.

Mr Brady: Thanks very much for your presentation. I do not want to be too parochial, but Newry has been mentioned a few times. I have had meetings with the GPs in Newry. You are saying that some GPs are for it and some are not. Their difficulty is that they have no information. One of the issues is the business case. You were looking forward to seeing the business case. The health centre in Newry is less than 20 years old; it opened in 1995. The GPs own it. They got bad press that they were hanging on because they wanted more money and all of that. That is not the impression that I got from them. They feel that it is still fit for purpose. The trust certainly needs premises, as it is under pressure because of the conditions that staff in that area are working. The doctors seemed to be saying that, if they came to a consensus and two sites could operate, they would not have a problem. However, I have been told by people who have absolutely no connection with the trust, the GPs, or anything, that sites have been earmarked. The doctors did not know about that when I spoke to them.

The doctors said that they were approached by, I think, council officials and a private developer. That developer was willing to build a new centre but said that they would build shops on the periphery because the footfall engendered by the health centre would bring business. It is like somebody saying, "I will build you a new house at the top of the hill that is better than your own house, but we are not going to tell you why we are doing it." Presumably it is about making money. You are saying now that it is difficult to see how GPs can buy into something for which there is no business case and that they really do not know anything about. That is one issue.

On the residential homes, when I contacted the Southern Trust about the statement that it put out after the Northern Trust — and this is now in the public domain — I was told that it put out a statement in answer to a query from 'The Nolan Show'. I continue to make the point that, if 'The Nolan Show' is dictating health policy, we are all in trouble; possibly more trouble that we thought.

Kevin made the point about the Southern Cross situation. That affected a private residential home in my constituency, and the trust had to step in. We are told that, statistically, at least one private home in England was going to the wall every week. How do you safeguard? I continue to make the point that people are now a commodity and a profit can be made from them, but it is not like closing down a factory and selling off the machinery. You have to find somewhere for those people to go, or, if they are to be retained at the same place, provision has to be made for that. Kevin mentioned that in relation to —

Mr McCabe: We address that on page 14 of our response by stating that there has been a deliberate policy not to place clients or patients in statutory residential homes. Under the comprehensive spending review, there has been a deliberate policy to close those homes to offer up the savings. We say that that has resulted in the referral rate being low to non-existent, which, in turn, ensures that the occupancy rate falls below 50%. A view expressed in the consultation document is that patients and clients do not want to go into such establishments, but we dispute that assumption. We conclude by saying that adverse publicity that such facilities are going to close, or are due to close, coupled with the trust's policy, has created a mentality of fear among the public. We say that the decisions are being made to set homes up to fail and make them ripe for closure. However, the way to address that is to reverse it and ensure that such residential facilities are populated and maintained. You would then have the other scenario that I outlined previously.

Mr Brady: The Southern Trust has told me the rationale. There is a very good statutory residential home, Cloughreagh, in the Bessbrook area in my constituency. It is very popular and also has a very good day facility. However, the trust is saying that it is not fit for purpose and that the RQIA is turning a blind eye to some of the inadequacies of that old building. However, surely that argument does not stand up. They are saying, in effect, that people are being kept in a building that is not fit for purpose and may be at risk. I do not necessarily accept that argument because, if there is a huge problem, it should be addressed.

Mr Swallow: The Committee should also take note of the fact that there are companies of rather dubious consultants hawking their wares everywhere to get public bodies to drop the tariff for private residential homes. That means that responsible private care owners cannot sustain care and, increasingly, have to charge top-ups and extras to sustain business. It is a radically unstable market, which is leading to closures because of reductions in tariff payments. Responsible providers, among whom we have members, are telling us that they cannot sustain even a private service here.

Mr Brady: I will finish with a point about the direct payments. In my experience, those have not really worked. I have experience of working in the advice sector. The independent living fund did work, but it is being abolished. There is a dichotomy there somewhere. A system that worked quite well is being abolished, but the other system is being pushed forward. As you said, families are ending up with a £6,500 redundancy package because they are the employer.

Ms McKeown: In addition, I do not believe that the individuals or their families are being told properly told that, if they opt for the direct payment route, they will effectively become the employer and that the whole range of employment laws, health and safety laws and everything else that comes with being an employer will fall on their shoulders. That is very disturbing. Equally disturbing is that we are now looking at greater use of direct payments for people who should be entitled to proper domiciliary care and people with disabilities. They were the great advocates for the system, and we backed them and supported that.

Mr Brady: It goes back to the point that you made at the start that there is a vision but the strategy is simply not there.

The Chairperson: Today's session is the start of trying to tease out some of this stuff. You have raised valid points about direct payments and the possibility that there is a directive from the Department to trusts to not put clients into residential homes. We will come back to that stuff and get some information on it.

Mr McAdam: I have a point on what Mickey said about places falling into disrepair. There is a blame game going on there. The RQIA is used as the reason for failure and closures, but this is privatisation by stealth. It is not just residential homes that are closing; it is daycare centres and many other things. The acute sector is a mirror image. The South Eastern Trust, for example, is geared to deal with 5,000 dermatological interventions — that is what it can do — but the capacity and need is 10,000. The chief executive will tell you, "If I am to hit my budget target, I have to buy that in from the private sector. I have no alternative." A market force is being used to privatise the health service.

Ms McKeown: We have spent a large number of years now looking at areas like residential care. Our desire is to see models of care that enable people to be independent but also recognise the need for the collective given how some people live and the range of services that they will need. A big mistake was made recently. There was an assumption that the people who live in the homes that were earmarked for rapid closure did not understand, but that was a big mistake. We saw very clearly that those people are just older than us and have more healthcare needs than we have. They know, basically, when they are being conned.

The Committee should take a more in-depth look. I have been part of the care homes project for a number of years. It has brought us to the health service in New York, as it is part of the partnership with us, health trusts and private sector people here. We have looked at the standards of care inside care homes and at what is most desirable. The most desirable thing is what the residents themselves want, because these are their homes. The core issues are around activity, personal laundry and food. Oddly enough, the issues are not just whether you have an en suite. We have over 200 private sector homes in Northern Ireland, and many of those do not have en suites. Much more important than whether you have an en suite is whether you need proper care with issues such as toileting and

dignity. That is the kind of service that our people are providing daily. The absence of that kind of service is hitting the headlines today. I think that, as a Committee, you ought to look at some of those places and see what goes on and hear what residents themselves and their families have to say about it.

The Chairperson: That is why we are getting this overview, and then we will break it down into the programmes of care to allow us to talk in more detail on a specific issue, whether it is residential, maternity or children's care. As I said, today is the start of that process and it will be useful if you can suggest or give us information. We will be talking to other stakeholders, the Department and the trusts. This is the major piece of work that we will be looking at between now and Christmas. We will be trying to tease it out. You are right about what you said in your opening remarks, Patricia. I doubt whether anybody has a problem with the vision of TYC. Tell me how it is working on the ground. We all represent local constituents. We are all part of the communities that we represent. Sometimes, we hear this stuff, but we need to try to get it right from the outset.

Mr Wells: I do not think that it is just as easy to gloss over the problems about the state of some of those residential homes. We had one in south Down and there were five residents, two of whom were due to move to nursing care. It was going to cost £800,000 simply to make the roof compliant. There was more than adequate alternative provision in modern private facilities in the area. At the time, it was a painful decision, but I have to say that now no one misses that facility. You could not have justified its continuance because it was going to cost so much to keep it open. In that circumstance, what is wrong with providing an alternative for those vulnerable people in the private sector, rather than spending precious finance from the Department on a facility that had so few residents?

Ms McKeown: You have made my very point for me, Mr Wells. Why were the only five residents in it?

Mr Wells: Because the rest were going to —

Ms McKeown: No. I can tell you. There were only five residents because the doors are being closed, sometimes officially but often by stealth. There are GPs who will report that they are told that there are waiting lists to get into some of our 39 NHS homes when, in fact, they are two thirds empty. There are not waiting lists, but decisions are being taken that there will be no more intake.

Mr Wells: What is wrong with that?

Ms McKeown: What is wrong with that is that, once you decide to close the doors of a home, you have, de facto, decided to close the home.

Mr Wells: No. If there is more modern, higher quality, private care —

Ms McKeown: Higher quality?

Mr Wells: Yes, with en suites and brand new facilities —

Ms McKeown: There would have to be proof that there was higher quality care. And I suppose that the point I make to you is that you should refer to the RQIA and see in what sector complaints about the quality of care originate. It is not the NHS sector.

Mr Wells: If the RQIA has an independent statutory role to ensure standards, and there is a brand new residential care home in the area with state-of-the-art facilities for vulnerable people, what is wrong with the board or the trust deciding to allocate provision to the private sector rather than to a run-down public sector?

Ms McKeown: I would like to think that it is about state-of-the-art care as well. Care is really critical here.

Mr Wells: If that is the case, what is wrong with the trust allocating a place to the private sector, rather than to a run-down building that is in the state sector?

Ms McKeown: There is nothing wrong with that. They have been doing that for a very long time; we have a mixed economy. However, what is wrong now is a direction of travel that talks about choice for

older people and then completely removes the choice of NHS residential care. That is the decision that has been taken. It is in 'Transforming Your Care'; it is spelt out in that document. It states that the health service will withdraw. So, where then is the choice?

Mr Wells: In nursing care, effectively, there is no choice.

Ms McKeown: If we have demonstrated, and we have done so with the King's Fund evaluating our work, that the highest standard of care is in NHS residential care, why would you close it? It is not an issue of whether there is a nicer looking home up the road. If you have got the better standard of care there already, why would you close it?

Mr Wells: Because you would have to demolish it and build a brand new residential home to —

Ms McKeown: It may well be that, in some instances, the backlog maintenance has been let go so far that these things have to happen. I have seen that, as you have, Mr Wells, so many times. I have seen entire hospitals run into the ground because nobody would spend the money on backlog maintenance and chunks of the building fell into the road. That is how bad it got, but it is not the right argument.

If I really want to pursue this agenda, I stop spending on backlog maintenance for the 39 homes that are out there, and erelong, a small hole in a roof becomes a big hole. I close the doors to new residents, and erelong, instead of being somewhere where there is wonderful activity and a great atmosphere and somewhere that is your home, it becomes the waiting room for the funeral parlour. If I really want to do that and I am in charge of the health service, I can. I put it to you that that is what the decision has been and that is what is happening.

The Chairperson: I remind people that Transforming Your Care is not just about residential care.

Ms McKeown: Absolutely, I agree.

The Chairperson: The reason why the unions got first pop was to give an overview of TYC. So, we need to be careful. We will go into the programmes of care, and some of the detail can come out then. You mentioned privatisation, the care partnership stuff and the lack of information coming from Departments. That is the stuff that we need to do as well.

Ms McKeown: Can I give one last piece of evidence? You really need to hear this.

The Chairperson: I am going to let Jim finish.

Ms McKeown: Could I give him one last piece of information related to his question?

Mr Wells: You are going to give it anyhow.

Ms McKeown: Grovetree House closed a few months back. It got a full facelift and a lot of money was spent on it, and then they closed it. It is an award-winning home. I do not see the rationale for closing it.

Mr Wells: Moving on to domiciliary care, I understand that there are still difficulties in attracting staff, even with the recession, in both the private and statutory sectors. Can you confirm or deny that?

Ms McKeown: There are no difficulties whatsoever. The evidence I will offer you for that is, once again, an award-winning partnership project — the winner of UK-wide NHS award — namely; the West Belfast and Greater Shankill jobs project. That project was a partnership between us, the Belfast Trust, the West Belfast Partnership Board and the Greater Shankill Partnership Board, and it created access for long-term unemployed people into entry-level jobs in health. One of the areas that we earmarked as having the biggest potential for jobs was in home care and the home help service. There were people literally queuing for those jobs. For every job, there was potentially 100, maybe 200, applicants. So, where the idea comes from that there is a problem in getting people into those jobs, we do not know. We ran out of vacancies in home care jobs in the Belfast Trust as part of that project, such was the number of people coming forward to fill them.

Mr Swallow: We do not have a workforce plan. We do not reflect the increasing age of the current workforce and where the new workforce is going to come from. That has been delivered in trusts that employ directly, and that is where the thinking is. However, the current state of the market is a pay-per-minute rate that finishes at the end of the visit, no allowance for travel, no allowance for wear and tear of the vehicle, which HMRC is very clear is part of the minimum wage, and a charitable statement that you cannot join a union because you are working for a charity. That is not exactly a model that is going to attract anybody into this crucial service. That is the model that commissioners are letting happen at the moment.

Mr Wells: You mentioned the Carrickfergus situation. You failed to mention the supported housing nearby and that there is a proposal for a very imaginative scheme of sheltered supported housing, which will give vulnerable people a front door, a back door and a warden. Many people feel that that is a better provision than residential care. Would you accept that some of the trends, which you are suggesting can be laid at the door of TYC, were happening anyway and long before TYC was on the table?

Ms McKeown: Not only were some of the trends happening, but we were supporting them. We have been in direct discussion with the health service for several years now about really imaginative, state-of-the-art assisted living facilities and about ensuring that we have the proper standards of care, a mix of independent living and knowing that there are people there to help when it is needed. We are completely into that; we were pushing that model and very often getting the response that, although they would love to, the budget did not allow it. However, there have been some pilots, as you know, which have been very successful, and we have supported them to the hilt.

Mr Wells: There was very little mention of that during the whole furore about residential care a few weeks ago. In the Carrickfergus situation, which you mentioned, the numbers were going down long before TYC was ever thought of.

Ms McKeown: But it has been a policy, Mr Wells, for quite a number of years. It did not just happen because Edwin Poots became the Health Minister. This policy of run-down and closing doors started under direct rule 20-odd years ago. It was a direct Thatcher proposal called Putting People First, which was supposed to be about pushing towards that wonderful public health model in your own home. However, it became a vehicle for privatisation, and that is how we ended up with, at its height, something like 450 private nursing homes in Northern Ireland. Anyone could have opened one in the morning, because there was no regulation and we were dealing with the aftermath of that for years. I do not know how many times our lawyers have had to have affidavits sworn by people who worked in the system to testify to some of the terrible things that were going on because the regulation was not there.

That move has been happening for a long time. This is why you sign up to the vision. You want to have a world where you and I could live at home for as long as possible with great support, but to get there, we have to be honest and decent about it, and not do it on the cheap. We should not use it as an excuse to create income or profit for a vested interest; that is not on either. This is not open and transparent.

Mr McCabe: Mr Wells raises a point, because the language in 'Transforming Your Care' is quite flowery. It talks about a range of choices and about people being looked after at home and in independent supported living. It even talks about a target of 500 new units over the next five years, but the reality, as Patricia said, is that it is aspirational. There is no funding. Who would not agree with that? It brings us back to the vicious circle in which we find ourselves in with the current provision.

Mr Brady: I want to ask about supported housing. In the Assembly a few weeks ago, the Minister for Social Development admitted that he was not reaching targets for supported housing. I thought I was going to get through this meeting without mentioning welfare reform —

Mr Wells: For the first time ever, Mickey.

Mr Brady: I did not want to disappoint you, Jim.

The Chairperson: I might have thought that you had sunburn.

Mr Brady: It has to be factored into all this as well. Although pensioners are not being affected, people coming through are going to be affected in the long term if the welfare reform proposals are put into operation. Hopefully, the majority of them will not be. Those reforms have to be factored in, particularly around supported housing and maintaining people in their homes, the role of the voluntary sector and the funding that is going to be available. All that has to be looked at.

The Chairperson: It amazes me what happens when I allow someone in for a quick supplementary question. There was no question there. We have raised some of those issues as well.

Mr Beggs: You mentioned that some of the healthcare providers were, effectively, forcing people to work under the minimum wage. Can you provide some information about that? This is very important; we have a duty to ensure that public money for the health service is not being used in that way. It would be useful to have that information so that we can pursue it.

You also mentioned how the Greater Shankill Partnership and the West Belfast Partnership have helped people to get jobs and fill vacancies. Is that type of planning, support and training available elsewhere? My experience with individual residents who need support in their homes has been of difficulty with staffing, and patients who wanted to come back home had to remain in hospitals or residential care homes. No staff are available to treat them and support them at home. Do you feel that there is sufficient support and training for people to take up such job opportunities?

Ms McKeown: No. That is precisely the kind of visionary idea that we had behind the project; if healthcare is changing, the nature of jobs in healthcare will change. What you should do is look at the existing workforce to see whether you can offer them new opportunities. That was precisely why the partnership with New York happened. They looked at how their healthcare system was changing. Instead of having 8,000 redundancies, which they had a one stage, they managed to retrain healthcare workers for new functions and new types of care delivery until they had zero redundancies. In fact, they were going into the barrios and making employment opportunities for people who did not have them. That is part of the concept.

Unfortunately, the west Belfast and greater Shankill project, which was due to be rolled out across the entire city of Belfast nearly two years ago, has been blocked by three Departments. Our vision of rolling it out, not just across the city of Belfast but the entire health service, has been stalled. We are hoping that there will be some further movement on that. We have been lobbying. All of the political parties support the project. There is not one single party that does not support it. There is no logic as to why it should be stalled.

I have to tell you, Mr Beggs, that we held seminars with our members around six or seven years ago. We talked to them about new ways of healthcare delivery; the whole concept of hospitals without walls, how they would follow NHS patients out into the community and how we would look for new types of training to deliver all of that. None of it ever happened. The system talked about it, but did not do it. The time is right to do it. You have to retrain the existing workforce. You, honestly, have to give up the moratoriums and hire people to do whatever is needed.

Mr Beggs: So, are trusts just making people redundant?

Ms McKeown: Yes.

Mr Beggs: I think that there was a bid for further redundancy money, rather than money for reskilling and retraining.

Ms McKeown: Well, TYC flags up 3,000 jobs to go. It actually flags that up in its paragraphs.

Mr McAdam: In some trusts, there are currently examples of people being offered voluntary redundancy and being replaced with lower-grade staff, particularly in nursing. I will cite school nursing as one model. All that does is dumb down the service. All that it is designed to do is to deliver less care at a cheaper cost. First of all, it is an outrage that voluntary redundancies should be used as the main means to save money. It just does not stack up.

Mr Beggs: I want to move on to hospital care. You indicated that there had been around a 10% increase in private-sector procedures and operations in NHS hospitals. Has any assessment been carried out by you or others that you are aware of as to whether full cost recovery is going on or

whether individual companies or organisations are benefiting privately by operating, essentially, in the NHS?

Mr Swallow: I will just say, Chair, that the NHS has never been very good at sending out bills. So, I would be very concerned about whether there was full cost recovery. The crucial issue that the Committee may want to consider is what the impact will be on targets and waiting times if we have a 10% growth in private procedures. That has not been established anywhere. It is a crucial issue now. If, unlike Scotland and Wales, we get into the band of increased private-sector procedures, how does that relate to cancelled appointments and extended waiting times?

The Chairperson: In fairness, that is a bit of work that the Committee has been doing. We are not looking at TYC in isolation. We are actually looking at healthcare in the health service. Part of that relates to cancelled appointments, missed appointments, private work, additional money going in to target waiting lists and how it fits into the care package for the individual. That will all fit into what we are hoping to achieve.

Mr Beggs: When additional pressures come along, are you aware of any cases in which, if you like, in-house proposals come forward, whereby the in-house team takes on additional work, does additional hours and gets paid additional money to, perhaps, provide the additional service cheaper than the private sector may be able to? Does that happen anywhere in the NHS?

Ms McKeown: The NHS benefits from hundreds of thousands of hours of free work. That is a fact of life, and you will know that, as you were a social worker. People on shift changeovers stay because they need to. That happens every day and every night in our service, so it benefits from that. The TUC did a study itself two or three years ago on the size of that. The value of that free working to the entire UK economy is enormous. So one of the things that you most definitely get from the NHS is that people go the extra mile and do it for nothing.

We have made quite a few proposals in the past as to how we might do things differently. We probably were the first to propose opening our surgeries at night-time. We might operate places like Lagan Valley Hospital round the clock in order that it might not close. We have made a number of very detailed proposals like that over the years, not all of which have been acted on. Some of it is about the system not being very good at changing the way it does things. It is a monolithic system and it is hard to make it think and do things differently.

Mr McAdam: To answer your question, the nature of the health service is that you rarely get a bidding situation. People will quite frankly tell you that, yes, this is the health service. What happens is that the health service is allowed to fail, and the task is given to the private sector on the basis that the NHS cannot meet the need. However, it is how that failure is allowed to happen, or is created, that is at the heart of this.

Mr Swallow: Let me add for the record that, since 2001, 1,500 domestic and catering workers have returned to the NHS from the private sector under a departmental circular that required a demonstration of value for money. So, the fact that every domestic in a Northern Ireland hospital is an NHS worker arises from a process that included that value-for-money testing that was required to actually return them.

Mr Beggs: I turn now to the issue of pressure on hospital beds and accident and emergency units. We have had trolley waits and people who could not get moved into wards being stacked all over the place. It seems very strange, under those circumstances, to be talking about closing down 180 beds. Even last week, when we discussed the Southern Board's problems, a number of other bed closures were discussed. What are your concerns that closures are being implemented before, if you like, the essential nature of the service has changed? There is an urgent need for those beds to keep our accident and emergency units flowing, but they are talking about closing them before the pressure has been taken off and the need demonstrated that alternatives are working.

Mr Swallow: As we understand it, the advice from the colleges is that bed occupancy should be no more than 85%. Bed occupancy in a number of Northern Ireland hospitals, and I am particularly mindful of the situation in the Antrim Area Hospital, has hit 95% and above. So I think that the Committee would wish to look quite carefully at whether we should remove any beds until we have sustained the clinically recommended level of bed occupancy.

Ms McKeown: In addition to bed occupancy, we are increasingly worried about the trend of saying that the quantum of health care necessary to keep a particular service in a particular place must be x; it becomes y when a number of beds are removed, and, therefore, the service goes. That is not unlike closing the doors of a home. So, we are particularly concerned about that. We have been around the health service long enough to know that there are back door methods of getting what you want, and if you want to close something or move it, you will do it by a back door method which will silence the people. You will say, "No, we do not do enough of those operations, so you are not clinically safe". It is very hard to argue against the claim that you are not clinically safe. That is something that happens all the time.

Now, why would you put such bed closures in when we are running at 95% bed capacity and we have had some pretty senior clinicians admit to us that we cannot sustain this? We as a union recently did a survey from our headquarters in London. It was a quick online survey across a significant number of staff, predominantly nursing staff, in the light of the Mid Staffordshire Trust crisis and the Francis report. The part of the health service that came out most at risk, unfortunately, was us. That is very worrying.

Mr Beggs: Are you able to share that survey or aspects of it with us?

Ms McKeown: Absolutely. We did put the information out publicly, but, absolutely, we will share it with the Committee. We were pretty shocked when we saw it. We released it around five or six weeks ago.

Mr McAdam: Can I just add one response, because I understand that there has been some discussion —

The Chairperson: It is a good job I like you, Kevin. *[Laughter.]*

Mr McAdam: This is for you, Chair. I know there has been some discussion about pharmacy being in some way to blame for the delay of discharges. There is a lot of work going on across the service in delivering 24/7. There are good bits of TYC that are working, and 24/7 working is changing the way in which the service is delivered. However, if pharmacy representatives were here, they would say that they alone are not to blame for late discharges.

The Chairperson: I probably need to declare an interest because I worked in a chemist when I was at school. *[Laughter.]*

Mr McAdam: They would say that this refers to hospital pharmacies; it is totally different.

The Chairperson: I actually ran the chemist.

Mr McCarthy: What is your opinion of how we are moving in TYC in relation to learning disability and disability? I am thinking of Muckamore Abbey and the pressure to have that closed up by 2015. Do you regard what is happening as sufficient to meet the needs of people with learning disabilities?

Ms McKeown: No, not in the least.

Mr McCarthy: How can we ensure that there are sufficient capabilities for that?

Ms McKeown: When we went into negotiations with the then Royal Hospitals Trust, when the Human Rights Commission did the report into Muckamore Abbey, we were told that the trust needed £30 million in order to make the proper transition for the residents of Muckamore Abbey into proper independent but assisted living. It was doable, but they said that the £30 million was not there. We have seen so much money wasted since we had that conversation, not just in the Belfast Trust but across this entire system. They could have done something about the fact that we have still got people in Muckamore who should not be there. I do not think the health system has taken seriously the fact that that needs to happen.

However, it is not just about emptying it, as you know, Kieran; it is about what happens next and what the range of support is. We work very closely with a host of organisations, such as the Carers' Association, Disability Action and a range of the disability organisations, and with children's rights organisations as well. They all have very good, strong and detailed views and have done work on

what needs to happen. That would require, in our view, what should have happened under Investing for Health but did not. That would require the Department of Health, the Department of Education, the Department for Social Development, the Department for Regional Development and others sitting down together and working out what each of their shared responsibilities was for that group in society. In fact, that is what a public health model would look like. If they did that, then you might find that there are resources in the system — not just health resources — that would make this work. I think it is doable.

Mr McCarthy: So, it is a joined-up approach?

Ms McKeown: Yes.

Mr McCarthy: The implementation of the Bamford report is way behind. What do you see in Transforming Your Care that can bring that up to where it should be?

Mr Swallow: No one will acknowledge the King's Fund finding that the unit cost per client in mental health here is 44% lower than that in England. I see plans, proposals and nice language, but I do not see an acknowledgment of that funding deficit specifically in mental health and proposals to correct it. Until we face that and make the proposals to correct it — I and Unison accept that it may involve some rebalancing, which is scary stuff — we will not really face up to the Bamford legacy, which has not been implemented.

Mr McCarthy: Exactly. I will go back to residential care and the fiasco with the closure of the homes. A new officer has been put in charge, and she said that they got it wrong and that, from her appointment, they will talk to the people in residential homes about where they want to go and not do anything against their wishes. Do you have faith in that?

Ms McKeown: Absolutely none whatsoever. It was disgusting and disgraceful. They were ignored, and they are now being lied to. That is still predicated on the assumption that they are stupid, which they are not.

Mr McCarthy: I wanted to hear that because that is very important. We thought that we were on a new roll with the appointment of the new officer.

The Chairperson: Did she ask to meet with the unions? Have you asked to meet her?

Ms McKeown: No. There are times when asking to meet the system is fed back to others as having been consulted when, in fact, you were not even listened to.

The Chairperson: I asked that for my own information.

Mr McCarthy: That answer speaks for itself. What is the use of honeyed words if the actions are not being carried out? That appointment was made only recently, and we thought that we would have seen some progress. Obviously not. There you are, Chair; we have a bit of work to do.

The Chairperson: Today has been very useful, but we still need a lot of information from you, including some of the stuff that you mentioned, Jonathan, on the King's Fund. As I said and will say again, you are key stakeholders, and you need to work with us on this. We might not always agree on everything as a Committee. Some of us might agree with you 100%, and some of us might only agree with you 50%. However, we can agree that we want to get it right for our constituents, for our public, and for my family as much as your family and everybody's family. That is why there needs to be a partnership between you, us and other stakeholders.

We have done a bit of work on tackling and trying to guide the Department on the issue of health inequalities. We can get into the argument about what is being done to tackle health inequalities in the areas that have the highest level of health inequalities or other issues, and that has not changed over the past number of years. I will allow each of you, if you want, to come in for a couple of minutes. How do you believe that TYC can be adapted to tackle and target health inequalities?

Ms McKeown: There is nothing in it about that.

The Chairperson: How do you think it can be adapted?

Ms McKeown: It ain't there. It was not designed to tackle health inequalities. It was designed to get us from 2011 to 2017 with a massive health budget cut, and it is time that we were honest about that. It is an accountancy tool to get us there.

Mr McCarthy: Chair —

The Chairperson: No. Let Patricia tell us.

Ms McKeown: It is not in it. If you want to tackle health inequalities, you have to shake the system up and go back to Investing for Health, which Sir Donald Acheson said was just about the best programme that he had seen in the English-speaking world. If we produce something as good as that, how come we have failed, 10 years later, to do anything about the level of health inequalities? The answer to that is fairly simple, and it is like what I said to Kieran: it required the system to talk to itself and do business with itself. That did not happen. It needed Health, Education and Social Development to do business. I will not have a pretend exercise and say that Transforming Your Care is anything to do with challenging health inequalities in Northern Ireland. It is not; it is an accountancy exercise. If we want it to be about more than that, then we go back to something like Investing for Health and we ask what that mean in respect of the Executive and each Department and the role that they have to play and how they do business with each other. There is new learning in this, and that is about delivering the public health model.

The Chairperson: We talked to the European head of the World Health Organization a number of months ago, and the recommendations that we brought forward were about themed approaches to the economy, to jobs, and to tackling and targeting health. So, the Committee knows that health is not just a Health Department issue; it crosses every Department. Kevin, I will let you come in on the issue. Do you believe that TYC can be adapted to address and deal with health inequalities?

Mr McAdam: TYC identifies some of the failures in the health service and looks to putting them right. One of the differences is the funding between acute and community services, and it seeks to move that. I do not think that anybody will disagree that that is a better way of treating. We have consistently said to the TYC team that you cannot do this without investment. It simply does not work. Indeed, the money that they set aside to move 7% from the acute care into the community has only been used to fund the bureaucracy of it and has not been used to deliver that change. So, there is a way of doing it, but we all have to be realistic and admit that increasing needs in the health service will require increasing funds. There is simply no other way of putting it.

You raised the issue that you are meeting the Health Minister on 5 July. That date is the sixty-fifth birthday of the health service. Maybe you might bring that to his attention to celebrate, first of all, the 65th birthday, but also to remind him that it is not for retirement.

The Chairperson: That is the same age as Jim Wells.

Mr McAdam: It is not about to retire, and I do not think, in your hands, it should be allowed to retire.

Mr Brady: It is just being pensioned off.

Mr Wells: It is actually 3 July.

Mr McAdam: You can remind him early.

The Chairperson: Give him an early birthday present.

Mr Swallow: In looking at TYC, we looked at the evidence that we gave your Committee in a previous meeting about the extent and nature of health inequalities here, and we tried to line up the proposals against those inequalities and, manifestly, we could not, because it was not there.

In respect of how TYC could better target inequalities, it could be useful for the Committee to have dialogue with the Chief Medical Officer. I think that he has some precise and clear proposals at the

moment that go into the wider issue of the replacement of Investing for Health. That is the source of learning for all of us about the extent to which inequalities are or are not being addressed.

Mr McCabe: I do not want to be cynical or pessimistic, but, unless I have been asleep, we had a scenario where the chief executive of the Health and Social Care Board, under another Minister, said that they could not run the system based on the current budget that they were given, and nothing has changed. Under another Minister, it is now doable under Transforming Your Care. The real trick there is that there is an agenda, and that is to live within the costs and to reduce costs where necessary. It is no different to what happened a few years ago, when the current Minister was an MLA, and he said that Skeagh House in Dromore should be kept open, as there were 102 residents there, but, suddenly, two years down the line, there is an inarguable case for closing that home and 12 others in the Southern Trust. The cynical side of me says that an overt agenda is being pursued.

Patricia and I attended a meeting with the Public Health Agency, and, in respect of health inequalities, that struck me as a major deficit. By its own admission, it said that it, as a substantive part of the health service, was not consulted on TYC. It is a limb of the health service, and it was not consulted under Transforming Your Care. You can only draw certain conclusions if that is the real world that we are being asked to accept.

The Chairperson: Maura, do you want to add anything?

Ms Maura McKenna (Health and Social Care Trade Unions): We have a very good name for TYC, we call it take your chances.

The Chairperson: I have heard that mentioned a few times.

In fairness, I think that today has been a good day. It has allowed us to look at that stuff. At times, we get people at that end of the table, and we are here to scrutinise and question. This is the start of the process of looking at TYC. We are going to go into some of the programmes, which will allow us to dig deeper into the reality of the good things and the bad things and how it impacts for that individual. So, any information that you feel we need, and any push in a specific direction, feel free to work with us closely on this issue. As I said, you are key stakeholders, as are others. And try to get the papers to us earlier.

Ms McKeown: One of the things that we did not want to do was to inundate you.

The Chairperson: I appreciate all that, Patricia. Once again, thanks very much for coming.