Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Transforming Your Care: Implementation Group Briefing

19 June 2013

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Roy Beggs
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr Conall McDevitt
Ms Maeve McLaughlin

Witnesses:

Dr Andrew McCormick	Department of Health, Social Services and Public Safety
Mr John Compton	Health and Social Care Board
Ms Pamela McCreedy	Health and Social Care Board

The Chairperson: I welcome Mr John Compton, Dr Andrew McCormick and Ms Pamela McCreedy. John, I will take this opportunity to congratulate you.

Mr John Compton (Health and Social Care Board): Thank you.

The Chairperson: Andrew, the briefing paper for today's session was received after the deadline that was given to the Department, and it could not be included in our main members' pack. It was e-mailed to members and has been tabled today. You will appreciate that it is a substantial paper.

I assume that you are aware that I cancelled an evidence session with officials a few weeks ago because a paper had not been provided on time. We wrote to the Minister about that. The paper on Transforming Your Care (TYC) was initially requested on 17 May for an evidence session at last week's Committee meeting, which I agreed to postpone at the Department's request. The Department had been given an extra week to provide the paper.

Andrew, you are responsible for the smooth running of the Department of Health, Social Services and Public Safety (DHSSPS), and that includes getting briefing papers to us. I have raised this problem with the chairpersons' liaison group, which is going to write to the Office of the First Minister and deputy First Minister (OFMDFM) about it. It is not right, and I am not happy about it. We are receiving papers after deadlines. I have tried to accommodate the Department on a number of occasions, but it is still the case that papers are coming in, having missed deadlines.

Can you explain why the paper was not received by the deadline that was requested, considering that the Committee and I agreed to postpone the evidence session for one week at the Department's request?

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): There is no good answer to that, Chairperson. I apologise to you again, and I am conscious that I have had to apologise previously. When I was preparing for this session, I read the Hansard report of a previous session that began with my having to apologise on this point. I will take this away and look at our procedures to find out what is happening. It is not acceptable to me, and I am very sorry that this has happened on this occasion.

I recognise that facilitating your business is fundamental to what we are here for. We need to make sure that, at every stage of our process, the Minister has enough time to clear papers. That has to be built into our work planning and timetabling. It is not enough to set a deadline that is close to your deadline. The work must be done well in advance to allow for clearance and consideration, especially if it is a range of issues and is complex. That requires better planning and an insistence that deadlines are adhered to. I undertake that that is what we will do. We will look at what went wrong specifically in this case. I am afraid that there are lessons to be learned from previous such cases. We need to look at the issue. Sometimes it is necessary to draw in information from a range of sources. We assume that it is better to get parts of the material in on time, even if some of it comes later. However, there are times when the whole picture emerges only after every contribution has been submitted . That is why we need to look at the issue across the entire system.

The Chairperson: Let me tell you where I sit. I have said to you and John before, privately and publicly, that I am not in this game to start a fight with the Department every week for the sake of it. I was minded to cancel today's session. That is how annoyed I am. Over the past weeks, we have tried to accommodate the Department, and papers still arrived late with us. We have a responsibility, and we have a job to do. I accept that you have deadlines, and papers for the Committee need to be cleared. However, on this occasion, I gave the Department an extra week, and papers still arrived late. That is not right and is not fair. To me, it is as if the Committee is not being taken seriously. I did not want to cancel today's session, but I was tipping towards cancelling and simply saying that the meeting was not happening. So I am asking you to go back to your departmental officials to ensure that it does not happen again. I do not want you to have to come back here again to apologise. To be blunt and honest, after three or four apologies, it would be nothing but an apology. Nothing has changed.

Dr McCormick: I understand entirely.

The Chairperson: That said, we will keep an eye on the situation. Hopefully, we will not have to go down this road again.

Dr McCormick: Thank you. Again, I apologise to the Committee for what went wrong.

This evidence session arises from the meeting on 9 May at which there was some discussion about the oversight of the next steps on the transformation programme. We have previously discussed the significance of the transformation programme. Given that it is a very ambitious programme of change that happens once in a generation, it requires us to have strong and effective governance arrangements to ensure effective programme and project planning. That is essential to the success of any change programme, especially one that is ambitious and affects a range of sectors. It is stated as a long-term and significant change. Given the way in which our governance is structured, and the fact that the review of public administration (RPA) led to the creation of a number of regional organisations as arm's-length bodies working with the wider system, including trusts, local commissioning groups (LCGs), special agencies and so on, it is important that things are brought together. Our structure is complex, and we must ensure that different parts of the system work effectively together.

Before Transforming Your Care, we have had an arrangement in place whereby the main regional organisations come together in the strategic planning group. I chair that group, which includes John, the chief executive of the Health and Social Care Board (HSCB); Eddie Rooney, the chief executive of the Public Health Agency (PHA); the Business Services Organisation (BSO); and other respective senior managers. That provides some flexibility. Organisations are represented, but if planning topics require specific individuals to attend, that is possible. So we have an oversight group that can look at anything. When there is a situation in which some of the delivery functions are in the Department, including aspects of health estates, planning and project management, and workforce control and

planning, there is complexity. It is not as simple as saying that the Department undertakes policy, strategy, planning and legislation, and the arm's-length bodies undertake all the delivery, so arrangements are needed that work for that purpose.

The strategic planning group looks at all the issues and brings together dimensions of planning change and oversight of finance and all aspects that matter. It is there to make sure that we look not only at Transforming Your Care but at the work on the public health strategy. Michael McBride attends and is a member of the group.

In implementing Quality 2020, we have to bring the different strands of change together. Transforming Your Care includes a range of recommendations and developments reinforcing policy on aspects of public health and quality, but it is not primarily about that. TYC's primary focus is the nature of service change. There is an opportunity for us to bring those different strands together to provide oversight of the entirety of the process at a regional level.

The next level of operational delivery is the transformation programme board, which John chairs, and it provides a clear oversight of the process. Again, it is regional in nature, and it brings the trusts together. The Department is represented as an observer at its meetings. It meets monthly and will get into a detailed programme and project management planning process. That involves the trusts, the PHA, BSO, the chairs of the local commissioning groups and senior managers from the HSCB and the PHA. That has a more operational focus that is designed to deliver and secure the key stages of change. The real work has to be broken down into pieces of work that can be managed on a more specific basis — work streams, which it is a slightly jargonistic term — and there are 11 programme of care work streams reporting to the transformation programme board. The briefing paper has some detail on that. That arrangement is to ensure that there is specific leadership and ownership of individual aspects of the transformation programme, that we get to a place where there are clear milestones, time frames and recognition of the benefits that we are trying to secure. The key test of any programme is the benefits that are realised and when they are to be realised.

This is a long-term project that will not show immediate return, but it is important to state the expectation and be clear on what is being attempted and be accountable. That provides the basis for clear management oversight and accountability. There are also some enabler work streams so that the wider system is supported by work on ICT, finance and workforce planning, capital infrastructure, capability and engagement, all of which Pamela, as the programme director and working through the transformation programme board, brings together. That is a key role, and an awful lot depends on bringing the perspectives together so that there are lots of interdependencies. Work on one project or work stream will sometimes depend on decisions or changes to be made by another. All that needs to be brought together, so the programme director role is critical.

That is the essence of oversight and governance of the transformation programme at the regional level. The Department is looking at the total picture, the entire system change and all the dimensions. The HSCB is leading on the management of the work streams to make sure that it all happens.

Members have a revised draft of the strategic implementation plan (SIP). It is not the final version but a work in progress. However, it shows the way in which progress has been made since the draft that was published on 3 July 2012. A revised draft was published last autumn as part of the consultation, and that was designed to draw together the main themes of change. I will not say a vast amount about that at this stage because it is still under review, and further work remains to be done. We are seeking to reach the end of the beginning to get to a stage at which there are clear project initiation documents and clear plans for the work streams that will take this from decisions on action following the main consultation into well-planned, well-organised action points. That is where we learned lessons from the events of April and May in order to make sure that we have a well-planned and managed process.

There is a lot to be taken forward in those contexts. Work is being taken forward on areas such as reablement, resettlement, workforce reskilling, integrated care partnerships (ICPs) and infrastructure. All those parts need to be planned to ensure parity of process, good decision-making and good support to the Minister. As you know, there is specific work on residential care homes. That is bespoke, unique work that is being led by Fionnuala McAndrew in the HSCB. Given the need for a regionally co-ordinated process, we have established a specific process, as the Minister has explained in statements. That is now happening; the regional process has started and is maintaining close working relationships with a range of stakeholders. A draft project initiation document for that came into the Department in the past day or two, and we need to finalise that and make it work. That is all very much about the governance side, and I think that it should give confidence that we have a clear

process and have learned lessons from what happened recently. We recognise that every stage requires openness and clarity with all the stakeholders, especially and fundamentally with those who are most affected by the changes. When that arises, it is absolutely clear that good engagement and good communication are required.

We are working from the regional level through trust and LCG level to local level. There has to be good communication at every stage so that we know what we are doing. As issues emerge, it will be possible to alert, clarify and be straightforward.

I am happy for discussion to go where you want it to go, but those opening comments answer some of the points that were raised on 9 May. John, do you want to add anything?

Mr Compton: No; that is fine. I think that it articulates where we are. We will answer any queries.

The Chairperson: It might be useful just for one of you to answer, rather than the three degrees.

Ms Pamela McCreedy (Health and Social Care Board): Another pop group.

The Chairperson: So you are now called another pop group. You are well aware that we have had a presentation from the unions on issues relating to Transforming Your Care and on some of their concerns. During the presentation, they told us that the Scottish and Welsh Governments had made formal statements that, under the reform of their health service, the principles of the health service would be upheld and that neither our Executive nor, indeed, our Health Department had done the same. Are they right? Is there a view that the Minister will make a statement to say that the principles will be upheld?

Dr McCormick: In one of the Minister's statements to the Assembly on the review last year — I cannot remember which statement — he said very clearly that he held to the principles of the NHS. It was in the introduction to one of his statements. Do you remember which one it was?

Ms McCreedy: I think that it was in both statements because it was in the original TYC document; it was expressed in written form in the document. I think that the Minister has referred to that on a number of occasions.

The Chairperson: Pamela, I think that the unions were saying that there was a formal statement dealing with the principles of the health service rather than a statement on TYC.

Dr McCormick: There are two important points. The context that you are talking about can refer only to the NHS in England, Scotland and Wales. England has the NHS constitution, which gives guarantees to the public and to staff about what will happen. As you said, Scotland and Wales have made formal ministerial statements of that nature. We have an integrated health and social care system, and not everything that is said about the NHS applies to social care. There are differences, which makes life more complicated, but the key point is that the Minister has said very clearly that NHS principles apply to our healthcare system. In fact, in practice, our social care system provides more that is free at the point of use than England, Scotland or Wales. That is the nature of the contract with the people. So there is no difficulty with statements by the Minister about the situation and a good comparability of undertakings to the public about what will be provided, including that it is fundamentally funded from taxation and free at the point of use. We have a "no defined benefit system", so if treatment and therapy are cost-effective, they will be provided.

The Chairperson: As you know, some, if not all, of the unions that we met have branches in England, Scotland and Wales. If statements are coming from the Scottish and Welsh Governments, it might be a useful idea —

Dr McCormick: They are in different formats, but the sentiment and political commitment are very comparable.

The Chairperson: Will you bring that back to the Minister, taking on board that he made statements about it, to reassure unions, on the back of what TYC is saying, that the general principles of the health service and what the health service stands for will be upheld. *[Inaudible due to mobile phone interference.]* That is not my phone. I assume that you did not smuggle in a phone. Andrew, that might need another apology.

Dr McCormick: I have done that before as well. *[Laughter.]*

Mr Dunne: Welcome again, panel; it is good to see you. Congratulations, John.

Mr Compton: Thank you.

Mr Dunne: Has it been the policy of the board for some years to advise trusts not to admit any new clients to long-term care in statutory residential homes?

Mr Compton: No, clearly not. I have not seen all the replies that you received, but the response from the Western Trust makes it quite explicit that there has been no such instruction from the commissioning organisation. This is about assessed need, and if people are assessed as needing residential care, the obligation is for the delivery organisation to secure that residential care. That has been the position for some time. We are aware that there have been changes in various units, and at times people have been using some of the units for respite care and so on, but the overall demand for residential care has dropped in the past number of years.

Mr Dunne: So you are clear, John, that there was no directive about admitting people to such homes?

Mr Compton: No; none.

Mr Dunne: What about the maintenance of such homes? Was there any policy or statement from the board not to maintain homes to a required standard?

Mr Compton: Absolutely not.

Mr Dunne: There is an impression that a number of homes have been allowed to fall into disrepair.

Mr Compton: Absolutely not. If the fabric of a building is in poor repair, the Regulation and Quality Improvement Authority (RQIA) quickly issues a notice. From discussions with colleagues, I know that they take that obligation seriously and invest the necessary money in such buildings over time. Many of the facilities will get infrastructural upgrades for bathrooms, toilets and electrics as well as upgrades for wear and tear on carpets, flooring, decorations, and so on. There is no instruction not to do that. If such a facility is being used, our expectation is that it be kept as fit for purpose as it practicably can be. Many of the facilities, as you know, are very old, which makes things increasingly difficult. The provision of the infrastructure — for example, bathrooms and toilets — is difficult because there are limitations on what can be accommodated in a facility. From a building point of view, it is not straightforward. However, there is no instruction to leave people in an environment other than one that is entirely appropriate and adequate.

Mr Dunne: So as far as the board is concerned, the statutory residential homes have been open for business as usual.

Mr Compton: Yes; they are open for business. I know that, as numbers have dropped, alternative placements have been used for respite care, day care and so on. As the numbers have declined over the past number of years, there have been moves to change and to close. On occasions, they have said that they will not admit any more individuals into a certain unit. That is entirely sensible, because if you are trying to deal with a situation, you have to manage the exit strategy. That has been done very successfully over a range of units in the past four years.

Dr McCormick: It is worth adding that there has also been considerable investment in newer models of care, such as supported living and other new forms of housing. Health and social care, in conjunction with the housing sector, has been investing considerable amounts of money in providing for new models, which will provide flexibility, support and a good context. There are lots of good, positive examples, which are the alternatives for the future.

Mr Compton: There is a range of facilities such as Barn Halt Cottages, St Paul's Court and Cedar Court. If the Committee has the opportunity, I would encourage it to go to see them, if it has not done so already.

Mr Dunne: Can you assure us that all the trusts are consistent about maintaining their properties?

Mr Compton: I would be very surprised indeed if any of the providing organisations did anything other than maintain their properties to as adequate a standard as possible. There are difficulties with some of the buildings because of their age, but I would be very surprised if that was not the case.

Mr Beggs: If I pick you up correctly, you said that the properties have been maintained appropriately during the period. Would you be surprised to learn that, on occasions, families have had to fight to get sinks unblocked? Their perception, therefore, is that properties have been allowed to run down.

Mr Compton: We should discriminate between two things. If there are circumstances that pertain to an individual and to the room that he or she occupies, a family may have had some difficulty. I am sure that that might be the case. However, I was answering a question about whether there is a policy that we will not invest money in a certain unit to fix electrics, carpets, kitchens, sinks and so on. That is not the policy. That does not mean that, from time to time, there have not been occasions when an individual family want something different to be done in a particular unit.

Mr Beggs: Would you agree that, if something routine needs to be corrected, it should be done, and families should not have to raise it at a higher level?

Mr Compton: Absolutely.

Ms P Bradley: I want to pick up on something that you said about residential care. I know about assessed need and how people are assessed to go into residential care. On the whole, it is the role of a social worker to make that assessment. Has there been less assessed need for residential care?

Mr Compton: Fewer people require residential care because as we have moved to a more extensive community care system, many more people have care provided for them in their own home than would have been available five to 10 years ago. A very substantial resource has been invested in that over the past five to 10 years to allow that to happen. Equally, some people choose different types of residential care. Two thirds of residential care are provided by the voluntary and independent sector, and about one third is provided by the statutory sector. People choose where they wish to go. That often depends on location, family opportunities and all sorts of issues. It would be wrong to communicate that the statutory side is the main provider of residential care in its entirety. The statutory sector is a small provider of residential care.

Ms P Bradley: I have another follow-up question.

The Chairperson: You told me that you had only a wee follow-up question.

Ms P Bradley: Elderly mentally infirm (EMI) and learning disability facilities are not included. We do not have many of them.

Mr Compton: We do not. We have a fair range of learning disability facilities that are not included in this issue.

Ms P Bradley: It is important to stress that point.

Mr Compton: I agree that it is important. The reason for that is that alternative provision through the voluntary and independent sector is less easy to secure and provide and tends to be on a smaller scale. There are more compelling issues for us to remain in that sector at this point.

Ms P Bradley: Before the Chair shouts at me, I will move on to what I really want to ask you about, which is direct payments. I know of circumstances in which direct payments have worked extremely well and also of circumstances in which they have not gone as well as planned. When the unions were in with us, they told us that you said that direct payments were in turmoil and not fit for purpose. Do you recall ever saying that, John?

Mr Compton: I do not recall those words. I recall saying that we needed to make our direct payment system more straightforward and simple to understand, because feedback that I got when I talked to people was that they were keen to use direct payments but wanted them to be simpler and a bit easier

to understand. The regulation of separate bank accounts with specific details is sometimes very off-putting for families. I indicated that, if we were moving towards personalised care, we needed to accept that we had to streamline a little, with the proper caveat that, as there is cash involved, there would have be a guarantee that the cash went toward the purpose for which it was paid.

Ms P Bradley: I agree with that. It is an extremely complicated system as it stands and previously when I knew of it. It is part of Transforming Your Care, and it will become much easier for service users and their families to use.

Mr Compton: We have made it clear that we do not expect and will not compel anyone to become a recipient of direct payments in whatever form. At the very least, individuals should have, in their personalised care, a straightforward statement of the amount of money that is available to buy their care. In discussion with such people and their families, we should find out how they want that money to be spent. In some instances, people will want to control the cash themselves, and we want to do that more simply and straightforwardly. In other instances, at the very least, we should be able to say to someone, "You have been assessed for 10 hours a week. If that turns out to be £150 a week, how do you want that to be spent? We think that you should consider this. What things would help you that you wish to consider?"

The Chairperson: Is that the same policy across all the trusts? Is there still some confusion? I think that it relates to a court case — I could be wrong — about a year ago on confusion about what direct payments can and cannot be used for.

Mr Compton: It is a complicated arena, and there was a court case about a year ago.

The Chairperson: In the Western Trust?

Mr Compton: The one that you are referring to was specifically in the field of learning disability and was about the capacity and capability of the individual to discharge the obligation of direct payments. There are things for us to work on and sort out, but the principle remains the issue. When there is a judgement in any judicial review cases and High Court cases, we will take that into account.

The Chairperson: That is where the confusion comes in. I have dealt with some of those cases in my constituency. It might be an idea to give us a written briefing on that, because I am led to believe that it is different across the trusts.

Mr Compton: You want a written brief on the outworkings of direct payments? Have I got that right?

The Chairperson: Yes, on the back of the judgement in the court case.

Mr Brady: Thanks for the presentation. My question is about the private finance initiative (PFI) model for health centres, particularly in Newry and Lisburn. I have met the GPs in Newry, and they were waiting for the business case in order to make an informed decision. The issue with Newry is that the health village is less than 20 years old and was opened only in 1995. It looked as though the Minister issued a ministerial direction and stated that there will be no business case — if I heard him correctly — the week before last. Does that mean that the business case did not stack up? The unions have suggested that the soft services associated with the health centres will come in under the PFI model. I want to check whether that is the case.

Dr McCormick: It is not that the business case did not stack up. It is simply that the Minister has the prerogative to take into account additional considerations over and above those that would be in a conventional business case, hence the process that has happened. He has quite reasonably taken the view that, in looking forward in a context in which, before very long, we may find ourselves in a situation in which not much capital money is available, if it is possible to secure good models of provision for primary care centres through a third-party development route, why not try it? If you do not try it and put the idea to the test, you will never know. So the key issue is to use the Lisburn and Newry cases to test the idea to establish how the procurement works out and to see what actually emerges.

As accounting officer, I had the responsibility to look at the business case through the questions of conventional assessment of value for money; that is my role. The Minister's role can quite reasonably include additional considerations, which is what happened on this occasion. He thought that we could

put the idea to the test. The business case has been done, and it has been through the two trust boards. On the conventional analysis, taking into account only accounting officer-type considerations, the evidence would point towards a conventional procurement. However, the Minister has the right to overrule that and say that we will try this idea. We will then learn lessons, not from a model or a management consultant's projection of what might happen but from what actually emerges from the cases. We will have real evidence that will allow us to judge and will allow the Minister to consider whether further centres should be developed through third-party development, whether we revert to conventional procurement or whether we find an additional creative model. That is the way it works. The documents exist and have been considered carefully, but the Minister has pre-empted the process by saying that he wants this to proceed. He is determined that this proceed, which is entirely appropriate from his point of view.

Mr Brady: That raises more questions than answers. What are the additional considerations? Will we get a chance to see the business case? Will the GPs get a chance to see it? I cannot understand how you can have a health centre, a PFI centre or whatever without the buy-in of the GPs. How can GPs make an informed decision without having access to the business case? It appears that they have been taken out of the equation. I have spoken to them at length about this, and the whole issue about the centres is that they rely on GPs buying into it, because otherwise it does not work. I wonder whether they will be given that opportunity. It is all very well issuing ministerial directions and saying that this is the way that it is going to be, but if you do not have the key players — GPs are the key players — and they are not being given the opportunity to buy into that —

Dr McCormick: They are also independent contractors. In that sense, they are also in the private sector so we have to have a contractual relationship with them, which means that it is not possible to disclose openly every single piece of information. In the end, there is a negotiation with them that has a commercial dimension. They are central players in the delivery of care, and our objective is to work closely in partnership with GPs in Lisburn, in Newry and in all the other places where development is required. They will be given the information that they need to take an informed view. They are commercial operators so they are very clear that they do not make their decisions until the whole story emerges.

Mr Brady: There are fundamental issues such as the site. There has been all sorts of speculation in Newry about where the centre may or may not be sited. There have been issues about private developers saying that they will build a centre with commercial premises around it and that the footfall from the centre will generate business, which, in theory, is probably a very good idea. What impact will that have on the existing site, which is very central? A number of issues have not been answered.

Mr Compton: You are talking about procurement. To be completely crystal clear about it: no building will be built if there is no formal agreement with general practice to use the building. That is straightforward. There is no question of the building being built without agreement with general practitioners in the first place.

Mr Brady: There would not be much point.

Mr Compton: There would be no point at all. The procurement process requires the particular model to specify a building of a certain size, which it will do in due course. The size and location will have been discussed with the general practitioners and others. There will probably be earmarks about a kilometre from a given point or something of that nature. I am sure that that will lead to a series of discussions about option A, option B or option C. All the way through, there will be discussions with the key participants. Andrew is quite correct in the sense that, although we can work very closely with general practitioners 90% of the time, they are independent contractors so we have to be cautious about that status 10% of the time. To be crystal clear: nobody will put up a building without having agreed it formally ahead of any decision to construct the building by general practice and other parties.

Mr Brady: With respect, do you not think that the business case is fairly fundamental to all this? If that is to be leapfrogged, in the sense that the ministerial direction is that no business case —

Mr Compton: I agree with you about parts of the business case. If the independent contractors wish to form themselves into a consortium, at which point they would bid to put up the building, giving them the business case and all the detail would give a financial advantage. We would be unable to do that because it would completely skew the procurement process. One party would have detailed information about the amount of money we anticipate spending and the amount in revenue. That

would be inappropriate. It is not inappropriate to have a full and frank debate with general practice about the nature of the building, the facilities that it wants in the building and the cost to individual practitioners as a consequence of moving into the building versus the cost that they meet in their current building. All that will be successfully concluded, because you cannot put up a building without that successful conclusion.

Beyond that, unless we had some sort of absolute signature to say that we are not interested in the independent side, we are in that difficult place.

Mr Brady: Are you confident that it can be successfully —

Mr Compton: Yes.

Dr McCormick: Soft services are not included. There is no plan to outsource soft services. Linking to what you said about sites, the Minister wants issues to be explored through testing the two cases. In the case of Newry, the idea was to find out whether there is a benefit from allowing the bidders to propose the site. That implies uncertainty at present because it is up to the bidders to come forward, but it might produce a better outcome. We will not know whether it produced a better outcome until we have been through the process. That is part of the evaluation of whether it works. That will be compared with a different approach in Lisburn, where the site will be more constrained. The idea is to have it on or immediately adjacent to Lagan Valley Hospital. That is part of how it should work. There are two different experiments. They involve using public money, but if they produce a different model of provision, the Minister takes the view that that could be a worthwhile outcome that might show us the way forward for the future. That is entirely reasonable.

Mr McDevitt: How much are we gambling on those two experiments?

Dr McCormick: It is not gambling at all.

Mr McDevitt: If they are experiments, by definition, it is gambling. It is a punt.

Dr McCormick: I do not think that a scientist would describe experimenting as gambling.

Mr McDevitt: Does a scientist know the outcome before he experiments?

Dr McCormick: It would not be a gamble. There is a judgement and a risk.

Mr McDevitt: How much is tied up in these two experiments?

Dr McCormick: Nothing is tied up yet. Nothing is committed until a contract is signed. We will not sign a contract until we have all the detail.

Mr McDevitt: What is the budget for these two experiments?

Mr Compton: In that sense, there is no budget. However, broadly speaking, if it is done this way, people sometimes quote working figures as 10% of the capital cost being the revenue cost. Is that what you mean? So if a building is put up at £30 million, the cost of it might be £3 million.

Dr McCormick: Those are ballpark figures.

Mr McDevitt: What we do know is that these two experiments did not pass a traditional business planning model in the Department; they failed.

Dr McCormick: The conventional procurement was better on a conventional analysis.

Mr McDevitt: What exactly is the difference between going down a conventional procurement road and going down this experimental road?

Dr McCormick: The difference is around the principles of third-party development. The development is undertaken and owned by the third-party supplier as opposed to the building being owned and controlled by the trust or —

Mr McDevitt: So the state's own rules — the rules of government — pointed to doing this in a way that kept the asset in the public sector and owned by the people. The Minister has set aside those rules and taken a decision to run an experiment, which means that the asset would be privatised.

Dr McCormick: The rules of government include the prerogative of Ministers to exercise their own judgement —

Mr McDevitt: With the greatest respect, you are an accounting officer, and what you will be hauled up in front of the Public Accounts Committee for is your ability to uphold the financial rules.

Dr McCormick: Yes.

Mr McDevitt: The financial rules state that, in these cases, it was best to build something and that the people of Northern Ireland would own it. The Minister overruled that, using his powers as Minister to say no and to privatise it.

Dr McCormick: He has decided to proceed with a third-party development on the basis that he thinks that it is worth considering.

Mr McDevitt: Am I wrong in saying that he overruled the rules of government to say that he would privatise it?

Dr McCormick: It is overruling advice. Advisers advise; Ministers decide. That applies to each and every decision that is taken. I am accountable to advise, in line with objective, evidence-based information on value for money. That has been done. The business case is there. It is entirely reasonable and appropriate for a Minister to take a different view. That is within the rules, which provide for that to happen.

Mr McDevitt: We know that this Minister took a decision to set aside the financial rules of government and use his ministerial authority to direct you to run a privatisation scheme.

Dr McCormick: To apply a third-party development.

Mr McDevitt: Which is a privatisation scheme. It is to take the asset and hand it over to the private sector —

Dr McCormick: There are a considerable number —

Mr McDevitt: — rather than the people owning the asset.

Dr McCormick: To be clear: GPs, as independent contractors, are in the private sector. When they own health centres or premises, they are, in that sense, in the private sector.

Mr McDevitt: That is not what we are talking about.

Dr McCormick: I am saying that it is not unusual —

Mr McDevitt: With the greatest respect, Andrew, we are not just talking about building GPs' surgeries with the bespoke model.

Dr McCormick: Of course.

Mr McDevitt: So that is settled.

Can you point out to me where the checks and balances are that mean that the Minister cannot take that decision every time that he has another capital spend opportunity under TYC? What is to prevent him taking the same decision every time a question arises under TYC to build something?

Dr McCormick: He has the prerogative to do so. We could have a philosophical discussion —

Mr McDevitt: No — it is a very practical discussion. It is a binary question.

Dr McCormick: There are considerable checks and balances, as you know very well, in the design of these institutions. I have official accountability. The Minister has political accountability. There would be room for challenge, either through Assembly or Executive procedures. The Minister is accountable in that sense. Those are the well-designed checks and balances in the Good Friday Agreement and the St Andrews Agreement. There are lots of constraints on what Ministers can do.

Mr McDevitt: With respect, I am not sure that the Executive would have the power to challenge either of those decisions. I think that you are stretching it, and I think that you know you are stretching it. So we know that despite the Minister's protestations that this is not, potentially, a charter for the stealth privatisation of much of the capital asset base, in fact, it is. If he continues to use his ministerial direction, and there is no legislation in place that puts a duty on you to point out to the Minister that this is contrary to policy, all that you can say to him is that it is against the financial rules and, if he directs you to do otherwise and says that he wants to privatise, off you will go.

Dr McCormick: Policy is for the Minister and the Assembly. I do not make policy; I advise on options and on the implications of policy options. That is the function of a permanent secretary.

Mr McDevitt: Your advice in those two cases was that they should be done "using conventional procurement".

Dr McCormick: My advice was that that was what the financial rules said. I have no difficulty with the Minister's decision. I do not disagree with his decision in this case. I offered my advice on the financial rules —

Mr McDevitt: You did not advise him to do that?

Dr McCormick: I do not disclose my advice. Again, that is part of —

Mr McDevitt: Did you advise him to do that?

Dr McCormick: I do not disclose my advice.

Mr McDevitt: This is an important point of public accountability. You told us that your advice was that the business case pointed to conventional procurement. You required a ministerial direction in order to go down the privatisation route. Did you advise him to give you a ministerial direction?

Dr McCormick: It is up to him to give a direction. As I said —

Mr McDevitt: What was your role? Did you advise him to give you a ministerial direction?

Dr McCormick: During my time in DFP, I was involved in working on the relevant guidance in the context of devolution, so I know it very well. The advice is that, if a Minister is considering a decision that could not be defended by the accounting officer on grounds of regularity, propriety or value for money, the accounting officer's duty is not only to make that clear to the Minister but disclose it. One reason that the Committee and the Assembly can have confidence in process is that the rules require that it be disclosed. This cannot be done in secret. I cannot turn up at the Public Accounts Committee (PAC) five years later and say that I have a get-out-of-jail-free card.

About 20 years ago, that happened at Westminster in the Pergau dam case. The Department for International Development had paid for a dam in Burma, and the accounting officer turned up at the PAC and said that he had received a direction. The PAC said that that was not good enough and that, from then on, an accounting officer must inform it at the time of a direction being given. So we have done that. If the Assembly is unhappy with that process, there are means by which to challenge it.

You have the means to table motions, and there is room for Ministers to take this issue to the Executive if that is what is felt to be necessary. Those procedures exist.

Mr McDevitt: May I ask one last question?

The Chairperson: You also did well with your supplementary.

Mr McDevitt: Thank you very much.

The Assembly did pass a motion two weeks ago.

Dr McCormick: I know.

Mr McDevitt: That motion states that you cannot do this.

Dr McCormick: As you know —

Mr McDevitt: The motion says, "Do not do this, Minister." The will of the House was, "Do not do this, Minister." You pointed out that we can table motions. I am asking you, as the permanent secretary, whether you will have to bring that to the Minister's attention when he comes to you with the next privatisation idea that fails a business case test — the regularity, propriety and value-for-money test. Will you have to advise him that it not only fails the business case test but runs contrary to the will of the Assembly?

Dr McCormick: That will be very clear to him. He will know that. As you know very well, responsibility for Executive decisions lies with the Executive Committee of the Assembly.

The Chairperson: Interesting.

I will come back to you, Roy. I want to bring Sam in first.

Mr Gardiner: Thank you, Madam Chair. John, may I also take the opportunity to congratulate you on the great honour that you will receive? There is no doubt that you will enjoy your day at Buckingham Palace.

Mr Compton: Thank you.

Mr Gardiner: I will ask you four related questions and would like four answers from you. Who will oversee the ICPs? To whom who will they report? Who will monitor their effectiveness? Will they include people who work in the private sector?

The Chairperson: This is on the back of the unions telling us that they were promised a paper on the governance of ICPs last year, but, to date, have not received one. We are trying to tease out some of the questions that came from our briefing from the unions.

Mr Gardiner: I want it sorted today; right now.

The Chairperson: You have lost your congratulations now, John. *[Laughter.]*

Mr Gardiner: Your honour has been taken away from you — no, it has not.

Mr Compton: The answer is relatively straightforward. The local commissioning group is the principal body that will oversee the ICPs, report on their success and be their performance manager. We said, for example, that, first, because everything cannot be done at once, the ICPs will concentrate on frail elderly services, diabetes services, stroke services and end-of-life services for those groups. We have commissioner specifications — in other words, the type of service that we want to buy from ICPs. ICPs will then come back and say how they will provide that. Remember that ICPs are professional networks of general practice, trust staff, voluntary and community organisations and individuals who receive that service. On the basis of how they propose to do that and meet the specification, we will transfer money in the normal way to various component parts of the ICP, and its delivery will be

managed and performance-managed in that way. So a local commissioning group will be front and centre and in charge of the ICP process.

Mr Gardiner: The Chair raised an issue with you, and the unions asked a similar question. Is there any reason why that letter was not responded to?

Mr Compton: No. After spending a number of months on this, we only recently got all of the final documentation on policy specifications agreed through the Department. There is no issue or difficulty. All of that will be in the public arena.

Mr Gardiner: Will they be notified in the very near future?

Mr Compton: Yes, there is no difficulty with that.

Ms McCreedy: The 17 integrated care partnerships also have a programme board, which oversees how they were established. I will not get into the technical jargon, but the project initiation document has been drafted and will be finalised by the end of June. Once final, it will be a public document, so it will be available to the unions at that point.

The Chairperson: The point is that the unions told us that they were promised a paper. I accept that the information will go into the public domain, but can they get that paper directly rather than you just assuming that they will be watching the website for its release?

Ms McCreedy: We can get it to them. There is absolutely no issue with that.

The Chairperson: OK, that is fair enough.

Ms Maeve McLaughlin: On Conall's point on Health and Social Care campuses, the Minister said to me during a BBC Radio Foyle interview — it is a matter of public record and can be checked— that the recommendations came from officials, both on location and the financial package. I want to put that clearly on the record.

Page 43 of the strategic implementation plan refers to a review of day care. An issue raised very vocally by the unions relates to carers and concern that the review will result in a decrease in the number of day care places. Will that happen?

Mr Compton: No, the issue when considering day care is that it is not a fixed position. For example, 15 years ago, in adult learning disability, the pattern was the traditional day centre model. Now, many such individuals leaving school go into employment or further education. It is not about removing day care; it is about making it appropriate for an individual. In the older groupings, day care may have much more to do with preventing social isolation, and there are different ways of handling that. The review will consider how we can imaginatively and creatively maintain a modern day care service across all of the groups to deliver Transforming Your Care, not reduce day care. Day care is quite important, and there will be changes to its patterns, but that is no different from what has happened over the past number of years. That is all that the review signals.

Ms Maeve McLaughlin: When will that review start?

Mr Compton: I think that they are commencing the work on day care.

Ms Maeve McLaughlin: The Chair outlined the timeline and the ability to scrutinise the implementation plan properly, but page 9 of the plan states:

> *"This Strategic Implementation Plan and the Population Plans which support it were initially submitted to the Minister at the end of June 2012".*

How can a strategic implementation plan have been submitted in June 2012 when the consultation on Transforming Your Care was not finished until January of this year?

Dr McCormick: A draft of the SIP was put out for pre-consultation in the summer, and it was made public in July 2012. It was part of the consultation in the autumn, which, as you say, concluded in January. Further work is ongoing to complete that strategic implementation plan. There is —

Ms Maeve McLaughlin: I find it extremely irregular that any implementation plan is put in place, whether draft or formal, in the absence of a full consultation. Transforming Your Care is probably one of the biggest shifts that we have seen in how health services are to be delivered. It is a huge shift that requires community consultation and public buy-in. How could we have a draft implementation plan in June last year when the consultation did not finish until January?

Furthermore, the document rules out the whole concept of equality impact assessments.

Mr Compton: I think that the Minister spoke about the original TYC document in November. He asked what the implications would be for population plans and the strategic implementation plan. The draft was to help to inform the consultation process. Sometimes, people challenge us on what specifically we mean. The draft population plans and strategic implementation plan were a signal of the direction of travel and the changes.

Then, on the basis of that information, which was freely and widely available across Northern Ireland, a formal consultation took place. That consultation concluded, and the Minister spoke on 19 March. Subsequent to that, we were asked, in light of the consultation, to review the strategic implementation plan to get to a point at which there was a document that joined up the whole process through consultation. In no sense was this done to short-circuit any consultative process. Throughout the process, all documentation has been made fully available in the public arena, and that continues.

Dr McCormick: A lot of change will happen as a result of TYC, but each and every change will be the consequence of proper process. There was a general level of consultation on the document in the autumn. There will be more specific consultations on a wide range of different issues, including all that is going on with statutory residential homes. Each and every material change in provision will be decided only after appropriate, fair, open and transparent process. That applies at every stage and to every level.

Ms Maeve McLaughlin: I reiterate that the strategic implementation plan is very specific. At the end of the plan, you go through each trust under a number of headings and sectors, and you outline actions and targets. How can we be sitting with that a year in advance of any consultation on the context? I will single out one piece: even the context of 50% of residential closures was not fully consulted on, and yet an implementation plan is already starting to roll it out. I find it irregular.

Mr Compton: I take the view that it has been consulted on. It was a clear, specific question directly asked in the 'Transforming Your Care: From Vision to Action' document. It specifically —

Ms Maeve McLaughlin: Sorry, but that finished in January of this year, and this document was put together in June 2012.

Dr McCormick: As a draft. They were initial draft proposals.

Ms Maeve McLaughlin: It still contains recommendations.

The Chairperson: What changes have there been from June last year to June this year?

Ms McCreedy: One of Maeve's points was about carers. The investment in additional work on carers was significantly changed from the original 'TYC' document. Indeed, we will need to significantly reflect that in the implementation plan—

The Chairperson: Can you tell us what changes were made from when the document was submitted in June last year to June this year?

Ms McCreedy: The changes come through in the strategic implementation plan and have been tracked. The main area of change is carers. There are changes to the mental health inpatient concept and to what happens at the Causeway Hospital.

The Chairperson: Rather than sending us another massive document, in June of last year —

Ms McCreedy: I gave you bullet points outlining the main changes.

The Chairperson: Give us the key changes from June of last year, when this was submitted to the Minister, until June this year.

Ms McCreedy: That is fine. No problem.

Mr Compton: We can do that.

Mr McCarthy: The unions raised this issue with the Committee last week as well. It is about enabling people with dementia and other complex needs to live at home. We all share concerns about that. How will the TYC recommendation ensure that domiciliary care packages are in place for the community? How much additional funding for domiciliary care has been allocated for 2013-14?

Mr Compton: Domiciliary care will receive a cash uplift of about £9·5 million in 2013-14. About 80% of that amount in demographic funding will go into the programme for elderly people. Some £7 million or thereabouts will be uplifted into services for elderly people across Northern Ireland, mainly in community care provision. Other efficiency lifts will increase that figure and, therefore, the volume of activity.

A specific amount of money will go into the implementation of the dementia strategy across Northern Ireland this year. I would need to check, but, from memory, it is a fund of about £1 million. I will confirm that figure for you — I just have that many numbers in my head.

Ms McCreedy: That is approximately right. The money for elements of the integrated care partnerships under TYC has not been allocated. We have identified what that would be, but, until we secure the money, we will not allocate it.

Mr McCarthy: Are you confident that there will be sufficient domiciliary care to provide for those who want to remain at home?

Ms McCreedy: Yes.

Mr McCarthy: Already, as public representatives, we are being told that the packages are being found wanting. There is a shortage of funding, and the community meals service has been cut.

Mr Compton: I have two points in response. Transforming Your Care is becoming mainstream. We are talking about mainstream services and Transforming Your Care being an influencer. It is about how we procure those services.

If we continued without making this transformational change, a 10-minute visit would become an eight-minute visit and then a place on a waiting list. We all know that that will not work. The transformation is about doing it entirely differently and means that we will procure services differently as well. We will commence those procurement arrangements in the course of this year.

The procurement will, of course, pay attention to cost and value for money, but not exclusively. It will also be about the social impact of the way in which we deal with procurement and the social added value. That leads to a real opportunity for communities to be able to do so much more. As they told us in the consultation process, they want to be able and enabled to do so much more.

We cannot go from where we are now to the end point in one big step. The three- to five-year programme is under way because we know that it will take time to switch from one to the other, but that is the direction of travel.

Mr McCarthy: I refer you to page 26 of the document, which states that quality improvement and cost reduction were based on a consultant's report on potential savings in hospitals. As I understand it, trusts believe that these savings are overestimated. What are the savings as agreed by the trusts?

Mr Compton: First, I would be surprised if they were overestimated. No one has said that to me, and I see senior people in the trusts regularly. The figure is 5%, which comes as a consequence of changing the pattern of care. It is not about removing 5% from hospitals; it is about changing a pattern of care: investment is made to put services in place first in order to get the 5% out. Under Transforming Your Care, we do not expect, for example, any change to hospital beds until the second half of 2014-15.

Mr McCarthy: I hear what you are saying, John, but is it not fair to say that a 5% reduction in hospital beds must mean a 5% reduction in the beds in hospitals?

Mr Compton: No, not necessarily. Hospitals do so much more than provide beds. You are talking about the efficiency argument. We send out to all organisations information on how their average length of stay compares with hospitals in similar locations doing similar tasks. We give them information on the percentage of day cases as opposed to inpatient and surgery and on people being admitted on the day of surgery as opposed to the day before. So we challenge them to be efficient, and that will be a continual drive. If we do not do that, we accept inefficiency, which is potentially wasteful and could, in the end, deny services to individuals.

Ms McCreedy: You are referring to the McKinsey report on efficiency. A document was prepared that illustrated to trusts where there would be opportunities for savings, but the plans that the trusts submit are what they would sign up and what they feel is deliverable. So they would not say that they could deliver it all. In each area, it varies very significantly. A hospital with a very short average length of stay could not generate such an efficiency so would sign up to a plan that reflected that.

Mr McCarthy: You know as well as I do that, even now, the pressure in hospitals is enormous. Last night, I was told that a 92-year-old woman lay on a hospital trolley for I do not know how many hours. That is totally unacceptable. Will we overcome such problems through what it is being proposed here? It is a gamble. Andrew, you said that you did not gamble, but it seems to me that this is a gamble with people's lives.

Mr Compton: It may be to do with the facilities in your constituency. We have understood the demand and capacity in that area and uplifted the money quite considerably there. It is important to state the fact that £10 million has gone into one facility to uplift the capacity and support in that area. So the expectation is that it takes time to put all that in place. This is about people and recruitment, and we cannot just switch a light on or off. If you are referring to the patient experience at the front door — in the emergency department — our expectation is that performance will be much better.

Dr McCormick: The context must be recognised. We are sustaining high-quality services. There are several real difficulties for the service, but the budgetary context is the most challenging that we have ever faced. NHS funding, from its inception in the late 1940s through to the financial crash, regularly increased by about 6% a year — that was the long-term trend. We are now looking at about 2% a year, which is a very big change. Thankfully, the service has been able to secure significant efficiency gains, but it means that there is strain and complexity, so it is difficult.
It is remarkable that so much has been adjusted. There is, undoubtedly, more to be done. In no view of the future does anyone expect 6% a year. That is gone, and radical adjustment is required. That is one reason why we need to apply a transformation-based approach that allows a new way of doing things, alongside keeping the system running. That is a very challenging set of tasks for all the trusts and for the HSCB as the general leader of the process. It is not without its difficulties. The cases that you have described and the cases mentioned earlier are difficult and unacceptable, but they are relatively few, and many good things are happening as well. We need to make sure that we harness the whole system to minimise and prevent bad things happening.

The Chairperson: Kieran, I will not stop you coming in with questions, but let us all try to focus rather than having one big build-up to a question and another to the answer.

Mr McCarthy: I have a couple of questions. Page 34 of your strategic implementation plan states:

"Community-based alternatives to residential care are increasing all the time".

John, you mentioned that earlier, and we accept that. Will you explain in detail the range of alternatives to residential care that will be available in the future? How do you plan to communicate successfully those possibilities to older people and their carers?

Mr Compton: We are trying to communicate all the time and indicate the nature of the changes and, therefore, the range of services available. The sorts of things we are talking about are support in people's home, adaptations to their home —

Mr McCarthy: That goes back to domiciliary care and the provision of funding.

Mr Compton: Sure.

Mr McCarthy: If the funding is not there, that is doomed. So you have given us an assurance and promise about that?

Mr Compton: Of course, and we understand that one of the touchstone elements is domiciliary care. We understand that that is one of the key issues and drivers. It is worth pausing to reflect on what the pressures will be if we do not attempt to make the change and make it successfully. There are no neutral positions here. There is no ability to say that we will leave it as it is because we know, because of the case for change, that it would be overwhelmed. Therefore, what we propose is, I think, very constructive and caring. I use the word "caring" because we are trying to provide a caring service, not just something that moves boxes around. These are people who have a right to a decent service. A caring service for the future: that is the objective.

Mr McCarthy: Page 43 of your strategic implementation plan states:

"A regional day opportunities model for learning disability will be developed".

Will you explain that further?

Mr Compton: That is to do with, I think, one of the things that I mentioned, which is that we are changing the pattern of day support opportunities for individuals with learning disabilities. That has changed dramatically over the past 10 or 20 years, so we want to ensure that there is an overarching approach to that: a joined-up arrangement with education, employment, future housing for individuals and the day-centre provision that people may more commonly understand. It is about putting all that together as a proper model for individuals.

Mr McCarthy: You must be consulting at the same time because that is vital. As a parent, I know that you have to consult those with whom you are dealing because they are the people you want to care for most.

Mr Compton: As you know, there are many tremendous examples of parents being enabled to create a whole range of day opportunities for their sons and daughters. One that springs to mind is Stepping Stones in Lisburn, which is driven and supported by parents. That is a tangible expression of responding directly to a parental drive, and there are other such arrangements across the Province. Those are the successes that we want to build on.

Mr McCarthy: I congratulate you on your award.

Mr Compton: Thank you.

The Chairperson: After all that? *[Laughter.]*

Mr McCarthy: After all that.

The Chairperson: You should have done that at the start.

Mr McCarthy: I know. I forgot about it. *[Laughter.]*

Mr Beggs: Thanks for your presentation. I want to go back to the Newry/Lisburn issue. What struck me about Newry is that the proposal is to replace buildings that are only 18 years old. Will you have to buy the GPs out of any existing contract because they will have built purpose-built buildings that may become redundant?

Dr McCormick: It is important to set that in the context of the nomination of the GP facilities and the trust buildings. The trust buildings that are relevant to the new model of care are much older, so the context there is mixed. The question will be this: what is the most viable bid? That will need to take account of existing contracts and obligations.

Putting some of those opportunities into the procurement process means that there can be different solutions. At the next stage, we will need to evaluate which of the bids that come forward is best. There is an opportunity to consider the point that you make, and we are very conscious of it.

Mr Beggs: I am interested in this because, in my constituency, Larne health centre was built in the 1970s and Carrick Hill is pre-1960s, and both are badly in need of improvement. How were Newry and Lisburn selected? Did you call for an expression of interest or did a developer walk in the door and say, "I will do this for you, mate."?

Mr Compton: No, absolutely not. All LCGs, including the Northern one, are being tasked to review where the next developments in health and care centres should be.

Mr Beggs: How were Lisburn and Newry picked?

Mr Compton: Lisburn and Newry were selected because they were further down the line with outline business cases for changes. Other buildings are being considered for change, but Lisburn and Newry were slightly ahead. If you want to accelerate the development of this process, you pick those furthest down the line. As Andrew said, we also wanted to select the ones that suggested that we could really test the alternative outworkings. If this is a successful model, we want to be able to test what it would be like to put together a centre when general practices come from a diverse arrangement in which they own their buildings, as opposed to a large health centre that needed to be replaced, and the issues associated with that. Also, there are implications associated with site location and whether a centre would be located close to or on an existing hospital site. A range of criteria was considered, but the overwhelming criterion was the state of readiness of the business case.

Mr Beggs: I want to move on to care for the elderly. We received a document on Monday and, as the Assembly was running at the same time, I have not had the time that I would have liked to study it. However, I saw little mention of the respite care that is one of the essential services provided by the current statutory residential homes. What will happen to the future provision of respite care if statutory residential homes are closed?

Mr Compton: First, statutory residential homes are not the exclusive providers of respite care, which is provided across a range of facilities. If the assessed need of an individual was for respite care, that care would be provided. If there was no statutory facility in the area, it would be provided in the independent sector.

Mr Beggs: All 27 private sector respite beds in Larne are occupied, and 17 of those are in shared rooms. Therefore, there is no space for any alternative at present. If you close the statutory residential home, there will be no respite beds in Larne.

Mr Compton: In any consultation on changes to any given facility, one of the key deciding factors on the timing is the ability to provide the existing residents with an alternative and suitable provision and maintain services such as respite care. Therefore, those will be part and parcel of any consultative process and the key issues on which any decision is taken.

Mr Beggs: I argue that respite care must be provided locally, along with supported housing, which is the other option. If I read the initial plans correctly, you have funding for only six residential schemes at present. Am I right in saying that you need more money and co-operation with the Department for Social Development (DSD) to facilitate a much wider range of supported housing in a variety of locations, thereby giving people options?

Mr Compton: I want to be very clear about this: in no way has DSD been anything other than very supportive of this. We chair meetings jointly with DSD colleagues. My colleague Fionnuala McAndrew chairs the planning meetings, and 250 sheltered and supported housing places are planned to open in the next — *[Inaudible.]*

Mr Beggs: In what period will those 250 places be available?

Mr Compton: I need to check the detail, but the approximate timescale is between three and five years, and the places will be across Northern Ireland. All of this is about making the transition from where we are to where we would like to be. It cannot be done immediately; it must be done in an orderly way.

Mr Beggs: From my reading of the document, you plan to provide 177 places specifically for older people in six units. If the plan is for only six units, not every town will have new supported housing.

Mr Compton: Remember that supported housing is not the whole solution, although it is a very significant and important aspect of it. The ability to enable people to remain at home is critical. When we talked to older people and their families, they told us that, above all else, they wished to be enabled to remain at home.

Mr Beggs: They also wish to be healthy enough to remain at home. We were lobbied by a constituent — I will not give the full details — who said that it was proposed that her 86-year-old mother, who was described as having end-stage dementia and not capable of rehabilitation, was to be discharged into the care of her elderly husband. Do you accept that there must be a detailed assessment of someone's capability and the support in place before they can be successfully discharged? There is concern that such support has not been there, particularly when a bed manager phones to say, without all the necessary arrangements being in place, that a patient is being sent home.

Mr Compton: Absolutely. Of course, I cannot comment on the case in question, but, if you let me know the details, we will follow it up. This plan aims to do quite the reverse of what you describe; it is designed to ensure a much more organised response to families. Previously, we were told that the lack of choice and alternatives meant that the burden fell entirely on the family, which is unacceptable.

The Chairperson: Now that you have said that you will look into it, we will give you a copy of the letter. We do not necessarily go into constituency cases here.

Mr Beggs: That is not my tactic either.

The Chairperson: I know that, but it has come up.

Mr Beggs: It is the general issue of people being pushed out —

The Chairperson: I appreciate that it is an example from your constituency, but the issue has also been raised with us.

Mr Beggs: My final concern is about people who have been in long--stay care at the likes of Holywell Hospital. We have been lobbied by the Society of Parents and Friends of Muckamore Abbey. The group is concerned about difficulties that may arise in the rehabilitation or relocation process. There are also concerns that some of the facilities built at Muckamore over the years would no longer be easily accessible. A purpose-built swimming pool was installed there not that long ago. Are you enabling the alternative models being developed to be placed adjacent to or in the grounds of Muckamore so that patients will be familiar with their long-term surroundings and able to use such facilities?

Mr Compton: I understand exactly what you mean. We are looking closely at redeveloping staff housing adjacent to the site as a possible alternative for some people, but not everyone. We are talking extensively to families about all of that. This is a difficult area, and families, quite rightly, want to be persuaded and secure about the choices made for their loved ones' care into the future. It is not an easy set of decisions to make or debates to have. The alternative is that a hospital would remain someone's permanent address, which does not seem correct either. This has to be about sensitive discussion and debate with individuals and trying to tailor solutions to individuals in those circumstances, which is the whole purpose of this process. I guarantee you that we are acutely aware of that sensitivity and will do that to the best of our ability.

Mr Beggs: One final question, if I may, Chair?

The Chairperson: You are pushing it, but go ahead.

Mr Beggs: At what point will you deem residential accommodation to be appropriate in the future? What level of support will be deemed necessary to require someone to go into residential care?

Mr Compton: There is a range of needs; it is not a one-size-fits-all approach. In some cases, matters of social isolation will be important. An individual may be relatively capable of looking after themselves but extremely socially isolated, and, clearly, social isolation may carry with it issues of personal neglect, mental health issues and so on.

Another possible scenario is that a person, for a variety of reasons, may be fairly unsupported. Perhaps their family has emigrated, which means that they are not living in proximity to the individual who needs regular and routine support and care. There may be a slight deterioration in their ability to perform the personal care functions that we all take for granted. Those are the sorts of issues that we would normally deem to indicate the need for placement in residential care: essentially, when an individual has the ability to perform about 75% of personal tasks and needs support with 25%. However, it is also worth reflecting that a number of people who go into residential care become frailer, more ill and have to move to nursing home care. So there is the issue of trying to avoid moving people from one place to the other. It really is better if we can get to a situation in which people can remain at home, within —

The Chairperson: OK, we get the sense of it.

Mr Brady: I have one small point on a housing issue that Roy raised. The Minister for Social Development admitted to the Assembly a few weeks ago that he had failed to reach the target under Bamford. If that has a knock-on effect, it will inevitably create problems for keeping people in the community, so it will have to be addressed cross-departmentally.

The Chairperson: Yes, but when we raised that issue with the Health Minister a couple of weeks ago, he said that it was not DSD's problem; it was the Health Department that was the problem.

Mr Compton: The truth is that it is complicated. It is not one or the other. What I can tell you is that the we know the number of people —

The Chairperson: The Health Minister said that it was his Department's issue and problem.

Mr Compton: The system knows the number of people who will be relocated — I do not personally know. One of the project work streams that we talked about is working on the 2015 date. I have had no signal that we will not meet that date. We will work with colleagues in DSD and use other solutions to get —

The Chairperson: If the problem is not DSD, what is the hold-up, John?

Mr Compton: Practical issues hold things up. Sometimes, planning is more delayed than we would like.

The Chairperson: On this specific issue, what is the hold-up?

Mr Compton: There will not be only one factor: for example, the streams of money coming through DSD and the Health Department have to align. Sometimes, DSD has the resource to do its bit, but we have not got the resource to do ours, and vice versa.

The Chairperson: The last time that the Minister was in front of us, that issue came up. The Minister for Social Development had mentioned it on the Floor of the Assembly. I am paraphrasing the Health Minister — I will let you go away and check the Hansard report — but he said that the hold-up was not with DSD but that the Health Department was at fault.

Mr Compton: If you will give me licence, we will check that and come back to you.

Dr McCormick: We are working very closely with DSD to resolve some issues that are between *[Inaudible.]* —

The Chairperson: I appreciate that, Andrew. The Minister for Social Development said that he was not going to meet the targets under Bamford, and then the Health Minister told us that the problem was with the Health Department.

As you know, the Committee held an inquiry into health inequalities. How do you believe that TYC will address health inequalities?

Mr Compton: Very straightforwardly, all the integrated care partnership work and where we are targeting that it is in what we call end-to-end commissioning. My colleague Dr Sloan Harper has a very interesting slide on diabetes in greater Belfast, which shows that 450,000 people in greater Belfast need to make health improvements. It also details how many people in Belfast have diabetes and are managing at home, how many people have diabetes that takes them in and out of hospital and how many people have very complicated diabetes. The first objective in the commissioning is to start with the 450,000 and prevent them from joining the 12,500 with diabetes that they manage at home, and to prevent those 12,500 joining the 3,500 who require hospital treatment. From my point of view, that is where the commitment is. That identification takes us into areas in which the prevalence of a condition involves a complicated set of issues. If that is done seriously, it should lead to a point at which health inequalities decrease.

The Chairperson: What was the involvement of the Chief Medical Officer? What input did he make to TYC?

Mr Compton: He was involved throughout and aware of all the issues. To my understanding, he does not have particular difficulties or problems with what we are trying to do with TYC.

Dr McCormick: As I said in my opening presentation, TYC complements and stands totally beside the work that we have been doing on the public health strategy through the legacy of Investing for Health, the work to replace Investing for Health with a new public health strategy — that is imminent — and Michael's leadership of the work on equality. Those have been absolutely brought together. Part of the reason for our having the SPG is to bring together those strands of work and ensure that the totality of what we are doing is effective.

Health inequalities are very difficult to tackle. We are working against the ability of those who have resources to use them for their own health. That is part of how things are. The responsibility on the state, the Department and the Health and Social Care system, including the PHA, is to row against the tide and ensure that there are good preventative interventions, good work at community level, which will mean targeting activity —

The Chairperson: OK, I appreciate all that.

Dr McCormick: — to endorse why the PFG targets to invest in public health are so important because, without those, the natural tendency would be for health inequalities to increase.

The Chairperson: The information in the TYC document is that the Chief Medical Officer has been involved in that at every stage. Does that include the PHA?

Mr Compton: Yes, very much so.

Dr McCormick: As John said earlier, we are now mainstreaming TYC. Mainstreaming means that all normal rules apply, one of which is that the PHA and the HSCB work together. As John also said, end-to-end commissioning is when we use the PHA. A commissioning plan can be approved only if the PHA, as well as the HSCB, agrees it. That dual lock is built into the legislation. This all matters, and —

The Chairperson: That is fair enough. I am just trying to make the link.

You will be glad to know that this is the final question. At the start of the plan, you give a rundown of the programmes, working groups, and so on, but there are no names for those involved in the expert panel. It states only:

"core membership to ensure continuity and understanding".

Who is in the expert panel? Have you decided on its membership yet?

Ms McCreedy: We can get you the terms of reference, which is probably the easier part. There is John, and we have representatives —

The Chairperson: You said "expert" panel.

Ms McCreedy: I am sorry about that. John chairs the panel, and we get the experts around the table. When considering older people, Age NI was represented on the expert panel; we had Philip McGarry on psychiatry; Seamus O'Reilly on A&E; Terry Irwin on surgery; and Tom Black from the General Practitioners Committee —

The Chairperson: Can you give me a list? It just seems strange —

Ms McCreedy: I can give you the terms of reference.

The Chairperson: This seems to be the only panel in the document without named members.

Dr McCormick: This panel may change as the issues change.

The Chairperson: That is fair enough. If you give us the terms of reference, we can read those.

Dr McCormick: We can give you the current membership.

Ms McCreedy: Nursing and social care are there as well. The terms of reference should cover the gamut.

The Chairperson: On another point that was raised, was there a view on having laypeople on any of the working groups to bring a wee bit of realism?

Mr Compton: Do you mean to the work streams?

The Chairperson: Yes.

Mr Compton: Work streams have to take account of the patient involvement, which is the patient and public involvement (PPI) process. We spend a lot of time on that, all staff are very much involved, and we spent an awful lot of time with the Patient and Client Council.

Ms McCreedy: Users and carers are represented in all key projects, including statutory homes and Bamford.

The Chairperson: That is fair enough. We will be coming back to this and looking at the work programmes.

Andrew, no more late papers.

Dr McCormick: We will do our best.

The Chairperson: No, Andrew, doing your best is not good enough — no more late papers.

Dr McCormick: Understood.

The Chairperson: Thank you.