Northern Ireland Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Health and Social Care Review

19 October 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Health and Social Care Review

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Members present for all or part of the proceedings:
Ms Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Michaela Boyle
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Mr Sam Gardiner
Ms Pam Lewis
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

Ms Catherine Daly	)	Department of Health, Social Services and Public Safety
Mr John Compton	)	Health and Social Care Board
Ms Pamela McCreedy	)	

The Chairperson:
I welcome Mr John Compton and Ms Pamela McCreedy from the Health and Social Care Board, and Ms Catherine Daly from the Department of Health, Social Services and Public Safety. It is good to see you again. John and his team will give a presentation and then I will invite questions from members.

Mr John Compton (Health and Social Care Board): Good afternoon and thank you for the opportunity to address the Committee. We have sent you material on the provision of the review and briefing notes. I will go through the briefing notes in an abbreviated form and highlight some of the important things. First, we will detail the Minister's thinking behind why and how we should have the review. That is reasonably straightforward; it is taken from his instructions. He has asked me to chair the review, which I do in an ex officio capacity. Although I am chief executive of the Health and Social Care Board, the governance arrangements are not through the board, and the argument for that is that we have a review inside the system but with strong, independent oversight and supervision. I will talk a little more about that.

The terms of reference are in the briefing. It is an exhaustive look at the configuration and model of health and social care provision in Northern Ireland. It indicates that there are restrictions to what we do: it is not primarily for the review to look at resources or at organisational shape and/or design; however, where the review feels it prudent or sensible to comment on those, we can and will do so.

We sent the Committee details of our structure and set-up. I am the review team's chairman and we have a review panel, the members of which are: Professor Chris Ham, from the King's Fund; Dr Ian Rutter, a general practitioner who is an adviser to the government in primary care in the UK, and he has an involvement with the Institute for Healthcare Improvement in America; Professor Deirdre Heenan, who is well known to most people, is based at the University of Ulster's Magee campus, and social policy is her background; Mr Paul Simpson is a retired civil servant who has 20-plus years' experience in looking at health and social care-related matters; and Mr Mark Ennis is chairman of the SSE in Ireland and comes with a business perspective.

The review team, which is the engine room of the organisation, collects and collates information. That is detailed for you as well. Despite the scale of the review, a relatively small team is involved in our arrangements.

Our approach has been to take account of what we are asked to do and then to make some order or structure out of it. We have articulated our approach in a paper as: health and well-being; access; safety; quality; and outcomes. Then we looked at the key themes. We have used

the "Esther" model: individuals' experience of the system — what works and what does not — to reflect on what would work better for the individual. We should not be talking about hospitals or community care and primary care; we should be talking about individuals' perspective and how they understand and receive care. That has been the approach across those themes.

We have very strong communication and implementation plans. We have an online survey that is due to go live shortly. We will also have a much more structured omnibus survey interview of 1,000 people across the Province, carried out by Ipsos MORI, to give us a view of what people think about the health and social care system. We have meetings involving many professionals and professional groupings and organisations, as well as staff organisations.

Last week, we had three substantial successful workshops attended by about 150 people, reflecting most of the professional groupings that work in health and social care. Because of the timescale, they were organised at relatively short notice, but they were very well attended. None of them concluded until 7.00 pm and all were well attended until that watershed. It was probably closer to 7.45 pm when people left.

We have indicated the general inputs and how we expect to use them. There are five points to our approach. We have a context and have completed an extensive and exhaustive literature review of benchmarking, best practice and national perspectives during which some of the panel members were extremely helpful. We have looked specifically at how we relate north, south, east and west. In that context, we have been to Dublin to meet the secretary general to talk about issues in both jurisdictions.

We have also done a detailed analysis of what is in situ. Moreover, we have had an economic impact assessment for which colleagues from health and economists from the Department provided information. The issue for the review is to present the Minister with an alternative or agreed model and then report. We have articulated a timescale as far as we are able. We are doing our best to meet the 30 November date; that is certainly the expectation at this point.

Emerging themes have been brought to our attention throughout the period across all the areas and gambits of health and social care provision. We may stray into some of those areas in questions. I will conclude at that point and answer questions as best I can.

The Chairperson:

OK. Thanks a million, John. At the beginning of the terms of reference you said that the review should take account of the Minister's statement of vision and the strategy for the Health and Safety Executive. I do not recall seeing that. Where can I find a copy of it?

Mr Compton:

He has done two things: he has issued a press commentary document stating that; and he articulated the key areas that he thought were important in his statement to the House. They reflected quality and diversity in using the community and voluntary sectors. A range of issues was covered.

The Chairperson:

Is there a separate vision and strategy?

Mr Compton:

No. As I understand it, there is a document that has been referred to on a couple of occasions.

The Chairperson:

You referred to an online and an omnibus survey: do you know the issues around the availability of broadband in rural areas? I am not sure how you intend to factor that in.

Mr Compton:

The omnibus survey is easier to do because it is an actual interview with individuals. It is structured; it takes account of age, sex, disability and geography. The organisation involved, which is a well-respected one, will carry out those interviews with individuals across the Province, so that is not really the issue. We will do our best to accommodate the online survey. The announcement will be made in the media towards the end of this week about the online survey because we will be communicating how to do it. If we find particular problems or difficulties, we will try to accommodate them. However, I do not anticipate major difficulties.

The Chairperson:

I do not want to ask all the questions, because members have other questions to ask. I will ask one more and keep another to the end, if I may. Paragraph 5 of the review states:

"Where the Review finds major tension, or contradiction, between its emerging view of the best way ahead and the extant constraints listed at paragraph 1 above, this should be raised for consideration by the Department as soon as possible, so that

the Minister can be advised... and give a specific steer".

Have any major tensions or contradictions come out of the consultation so far?

The Chairperson:

Not so much. In the commentaries that we have had to date no one thinks that the system can be sustained in its present format; the thought is that change is important. That having been said, it is not about any criticism of the existing system because this is future-looking. It is about how to organise a system for the next 10 to 15 years rather than being a commentary about what has passed in the previous 10 to 15 years. I am not aware of any significant contradictions at this stage. That is not to say that there may not be as we go through the process; but, at this stage, no.

Mr Wells:

I apologise, John, but we have met many hundreds of times, so you will not miss me too much. Do you agree that this is an even more challenging document to produce than Developing Better Services (DBS)?

Mr Compton:

The short answer is yes, in the sense that it is not really looking specifically at hospital configuration. It is looking at the total service from the point of view of the patient experience. Therefore, for example, in some of the debate that we have had, most of the emerging themes have not been about hospitals. They have been about how to deliver the concept of personalised care, particularly for older people; how to promote health improvement by a preventative strategy, such as some form of Head Start programme for expectant mothers through to children who are aged five, and how to deliver and accelerate the Bamford agenda. There has also been discussion about hospitals, but the most important debate at this point is how to organise our primary care; by that, I mean general practitioner services, community health services and community care services. On the basis of what people have been telling us, those are the issues. Therefore, in that regard, it is a more complicated thing to do than DBS.

Mr Wells:

I am tempted to ask you what you do after lunch. Let us be realistic about this. Given the time span for delivering better services and the time that you have been allocated, even if the deadline of 30 November slips slightly, is it not an absolutely massive task to carry out such a fundamental

review of everything from the cradle to the grave in the health service in such a short period? Is it possible to achieve it? Are you confident that it can be done adequately in the squeezed time frame that you have been given?

Mr Compton:

The proof of the pudding will be in the eating in respect of what we actually produce. The point is that no one is approaching this matter from a standing start. It is not as if many of the issues are not well known, well articulated and well documented. At one level, this is about the collation of all that information into one piece of documentation. However, I do not think for one minute that you can assume that any document, whether it is done in eight or 10 weeks or eight or 10 months, can be encyclopaedic. The task is to try to take one or two big building blocks, set a direction, deliver a model of care, but, importantly, indicate how you might begin to implement that model of care. It has been put to me that the people who did other reviews were good at doing the reviews but not so good at talking about the implementation pathway and about how that should take place. However, I do not know whether that is very fair, because I am sure that they did those reviews with the best intentions. In this particular review, we want to indicate what is possible in 2012-13, 2013-14, 2014-15 and beyond.

Mr Wells:

Are you still sticking to the 30 November deadline?

Mr Compton:

At this point in time, yes.

Mr Wells:

How far down the line do you think you have got?

Mr Compton:

We are pretty much on target for 30 November. As I said: when you look at the five areas and our approaches, the benchmarking and literature review are substantially complete, the assessment is substantially complete, the health impact is substantially complete, and we are in the middle of a substantial consultative arrangement, which will include six public meetings. Those meetings will be organised for the end of October or beginning of November, and they will take place across the Province to give people an opportunity to participate.

Mr Wells:

I do not know if you listened in on the meeting that we had last week or those in previous weeks about the composition of the review group, but there was implicit criticism of the presence of the two consultants from Deloitte and the lack of representation from the local commissioning groups. Are you aware of that criticism? If so, is anything being done to address it?

Mr Compton:

I am aware of it. It goes without saying that no matter how you do this, there will be commentary on how it should be done. To set the record straight, we have all the necessary approvals that are required for how we approach this matter. We are essentially using staff substitution. In practical terms, we have had a couple of extra people to help us. We are not asking anybody else to write the report — let us be clear about that. It is being produced through the review panel and by us.

Although the Minister set the parameters and chose the individuals on the review group, he made it clear to me that I was free to speak to whoever I wished to speak to. We have made it clear that we will have very extensive engagement, given the time constraints, with all parties, and have begun to do so. It will include all professional groups, not just senior professionals. For example, on the social care side of the house, we are using the social care registration body to run two events for us. It is inviting anyone who is registered. We are not trying to constrain this in any shape or form. There will be a nursing review group, largely made up of senior professional practitioners at nursing level, in the middle of all of that. We have had a number of meetings with, for example, general practitioners. You can replicate that all the way through with other groups as well, so I do not believe that we are constrained in who we talk to. I am aware of the fact that, no matter how we approach the task, there will always be people asking whether we have thought of this or asking whether we should do it that way. I think the important thing is to get on and deliver, I hope, a responsible and well thought-out product.

Mr Wells:

If you achieve all of that, there will be a knighthood in it for you. It looks like mission impossible to me, but good luck.

Mr McCallister:

And that is a promise from the new Minister. *[Laughter.]*

Mr Wells:

I do not know what the ladies will get, but he will get a knighthood.

Mr Compton:

A holiday would be better.

Mr McCarthy:

Thank you very much for your presentation. I have three short questions. Will you assure the Committee that full consideration will be given to addressing demand through an emphasis on prevention and early intervention in public health and, furthermore, that it will go beyond just reviewing existing policies and examine new opportunities?

Will the review look beyond the spatial provision of services and examine the profile of spending in Northern Ireland. For example, will it examine the relatively lower spending per head on mental health services and learning disabilities compared to other jurisdictions, despite higher needs in Northern Ireland? Finally, a recent study has shown that 14% of over-65s in the UK are malnourished. Where will basics such as nutrition come into the team's thinking in the context of a nutritional strategy, which outlines an improvement in standards of food provision, at the same time that trusts are tightening their criteria for community meals in order to save money? In my opinion, that will inevitably cause a lot more people to go hungry, particularly elderly people in rural communities.

Mr Compton:

Prevention is a very strong theme in the document; I think I have indicated that already. If you look at the younger age group, the Head Start type of programme is something that has been pushed our way. However, it is not just in that arena. It is worth reflecting on the fact that health and social care is accountable for only about 10% of a productive outcome for people in life. There are other things, particularly for older people, such as housing and all sorts of other things, that have an implication too. We are mindful of that, and have the latitude to make recommendations. The view of some panel members is that a more profound and authoritative way of ensuring joined-up government is quite important in that context. I am sure that there will be much more debate and discussion about that before the report is ready. I can give you a very strong assurance that the whole preventative side is there.

The review can certainly comment on the spending in Northern Ireland vis-à-vis the rest of the UK. If you look at a pie chart showing how we currently spend our money, perhaps one of the review conclusions might be that the pie chart should be redrawn. That might mean that the percentage of money spent in areas such as mental health, childcare, or care for older people should be slightly greater and the money spent in our hospital sector should be slightly less. That is a theme, and it may well form part of the conclusion, so there is a clear element involved in looking at that.

As regards the over-65s and older people, a couple of things have been presented to us and on which the review panel has contributed. We should celebrate the fact that in our society people are living longer. The majority of them live fairly well, happily and harmoniously. We are in danger of creating the impression that, simply because someone is aged, he or she is a burden on the rest of society. That is the wrong starting premise. There are a million and one definitions of personalised care, but, simply, it means that individuals have greater control over their life and choices. It is very important that they have control over the choices that deliver proper benefit to them. In that regard, things such as nutrition, heating, safety and security are all very much part and parcel of where we are with the review. I would be surprised if you did not find some commentary in the review that articulates those principles and views.

Mr McCarthy:

I am happy to hear most of what you said, John. You mentioned Bamford, which is a very important subject for me. Mental health has always been the Cinderella of the health service in Northern Ireland. I hope that that and learning disability will be raised. We have had experience of delivering meals to older people living in the country. It is beneficial to their health, but there is also the social aspect. It is excellent having somebody knocking the door to deliver a meal. But that has been challenged, because the bar has been raised. I hope that you can do something to turn that around.

Mr Compton:

The current model carries with it that inherent difficulty. I am not sitting here promising the sun, the moon and the stars, and that we can fix everything overnight. A different model has a different view and a different orientation. One thing that has been brought to our attention to date is the really damaging effects that social isolation has on older people. If we do not address that

and think about how to address it, we will create other problems in the health and social care system. Of course, the solution does not always lie with having a lot more professionals and stuff like that; it lies more with enabling local communities to have greater involvement: and local communities want to undertake that involvement. It is not about transferring false responsibility to individuals; it is about working together.

Mr McCarthy:
Thank you. I have many more questions, but I am sure that other members will have them to ask.

The Chairperson:
We have another quite heavy session coming up, so we do not want this session to last overly long. I ask Members to keep their questions short, and I ask the panel to do likewise with its answers.

Mr McCallister:
The panel is very welcome. Your focus has to be on patients and on improving outcomes. That will mean looking at things such as where people access the health service and how to improve the point of entry to the system. I assume that you will be looking at some A&Es, the people who need to be there, and how that can be improved. How do you see that evolving, and how do you see the patient's journey through the health system improving? It works very well for some, but for others it can be a bit of a nightmare and does not always deliver what they want.

I was also very interested in your comment about joined-up government, which we all hear probably every day. Even for us, when we are, supposedly, making policy, it is proving to be a lot more problematic to achieve. You used the example of housing. Poor housing, bad diet and the whole health inequality agenda have a huge impact on health. One Department could have one approach to supported living and another might do something else. How do you hope to achieve joined-up government? How do you hope to get buy in from other Departments so that health is not left with the burden of all of this and that we get the message across that health is the responsibility of all government, not just the Department of Health, Social Services and Public Safety?

Mr Compton:
There are two things. First, patient outcomes and A&E will feature in the debate. Secondly, I

was signalling earlier that there is a tremendous interest in a different way of handling general practice. Ian Rutter, in particular, has been very helpful about describing how that gets handled differently. This is all about ensuring that people go to the right place at the right time, and that they can go to the right place at the right time. You will find that there will be some commentary on that. One of the driving forces for the whole thing is service resilience, quality and outcomes. For example, if you are asking people to travel, you cannot simply ask them to travel; you have to ask them to travel for a purpose, and the purpose is that the outcome will be better. As yet, it is not defined, but I am sure that you will see things like that in the report.

There are one or two ideas. It is only a report, and we have to suggest why there might be a different way of handling joined-up government. However, since it is not finalised, I cannot indicate what they will be yet.

Mr McCallister:
We definitely look forward to reading it.

Mr Compton:
We have had one or two very clear and assertive statements about the sort of things that might make it work. We have not written the report yet. We are in the process of gathering information and there will have to be some distillation. However, I would be surprised if the report did not have a recommendation from our perspective as to how it might be delivered.

Ms Catherine Daly (Department of Health, Social Services and Public Safety):
As John said, we cannot pre-empt what the report will say. However, the Minister is extremely keen to ensure that there is joined-up working across all Departments in key policy areas, and we will be seeking to take that forward at departmental level when the recommendations are implemented.

Mr Dunne:
You are very welcome. Obviously, this will be a major review. First, is it true to say that the review is cost driven? Is it about cost or is it about efficiencies and making things happen better? Secondly, last week, local commissioning groups attended the Committee, and we were all impressed with their openness and hands-on experience. What input do you see them having to the review? Thirdly, consultation with patients is paramount. How are you going to consult with

patients? I know that you have mentioned six meetings. It does not sound a lot, and I appreciate the fact that you have a limited timescale.

My fourth point is about staff morale. The perception is that morale in the service is extremely low. I know that you are looking more at processes and procedures rather than at individuals. However, they interconnect. Everyone is aware of staff morale, and the Committee is very concerned about it. Improving it would go a long way towards improving the health service. How do you feel that you could change attitudes and encourage more people into the service, as opposed to depending on short-term fixes? For example, you could bring people in, develop their careers in the health service and give them an assurance that they will be there.

Mr Compton:

The review is not primarily driven by cost: that is not the real issue. The budget settlement is the budget settlement, and we have not been asked to reduce it in any shape or form. The expectation is that at the end of this period we will be spending £4·65 billion through the Department of Health, Social Services and Public Safety and the board and, at the end of the review, we will still be spending £4·65 billion. It is for us to comment if we think it is appropriate to do so — either it needs to be greater or smaller — but this is not primarily a cost-driven issue. Primarily, it is about how we create a service that is resilient, sustainable, does not fall over and does not keep running into crises. It is about managing change rather than waiting for change to happen in a haphazard manner. It is also about how we look at the actual evidence with regard to what qualitatively produces a better service and, therefore, better outcomes for patients.

Of course, at the end of the day, money becomes important as well, but the driving issues are much more to do with service resilience and the quality, outcomes and experience of patients. That is where we are coming from. We are not naive about money; we realise that is an issue.

Local commissioning groups are important. We are meeting them, and they will have a formal meeting shortly with the panel members. They have already met some panel members in various arrangements. We will continue to do that, and they will continue to be very much involved, particularly in the debates about changing the possible way forward of primary care. They are central to discussions on those sorts of issues.

We are endeavouring to do our best in the time that we have to allow people to participate

either through the online survey or through the public meetings, and we are negotiating with the media on a range of local events and programmes that will give people the opportunity, we hope, to be informed and to contribute. Anyone can get in touch with us. We will publish all of this shortly.

Mr Dunne:

Good. Communication is so important.

Ms Pamela McCreedy (Health and Social Care Board):

We met the Patient and Client Council very early and took cognisance of the top 10 priorities in 'Rural Voices Matter'. That has helped to shape how we approach the work that we are undertaking. The Patient and Client Council will also facilitate a lot of the public meetings, and, on the mental health and learning disability side, we are working through the Bamford monitoring group to get the patient care view and aspect as well. So, in addition to the online and public submissions, we are working with the Patient and Client Council to try to secure as much of that public voice as we can.

Mr Compton:

You also asked about staff. At the end of the day, they are central to this. We met staff last week, and there is a burning desire for change. It is palpable; that is all I can feel. People feel frustrated about the fact that they want to make change, and they have felt inhibited in some ways about some of the changes that could be made. A key message that came across is the need to re-engage staff. So, we will do our best to do that. As I say, we have a programme and an arrangement to meet with the staff side. We know that they have anxieties and concerns, and we are coming at this very straightforwardly and very honestly and will listen to whatever is said in that regard. That is not a promise that everything that is said will be taken forward, but it is a commitment to listen.

Mr Durkan:

Thank you, John. In an answer to one of Gordon's questions, you said that the review is not cost driven. However, that is, and will be, the public perception of it. A good communications strategy is so important to sell the review and its findings or proposals, especially because you will have to put things in a more positive manner. You answered one of Kieran's questions earlier by saying that you have used a "pie chart" analogy: if you spend more on mental health,

you will not have as much to spend on hospitals. However, you should say that if you spend more on mental health you will not need as much to spend on hospitals.

Mr Compton:
I accept that.

Mr Durkan:
I am pleased that you said that you had been to Dublin and met the director general, and I and the Committee are very pleased with the Minister's pragmatic rather than political approach to cross-border co-operation on health. Have you been able to identify any specific areas where enhanced collaboration will help realise savings as well as benefit patients and service users?

Mr Compton:
It starts from the simple premise that Northern Ireland has a population of 1·8 million. There needs to be recognition that we cannot successfully run a total health and social care system on our own. Sometimes people think of the very obvious things such as paediatric cardiology and so on as the solution. In the past, we have tended to wait until we had that difficulty and then pragmatically worked closely with colleagues across the border to solve the problem. I think there is increasing realism that we need something a little bit more formal than that, because there are tremendous opportunities for both jurisdictions to assist and work with each other North and South. We will obviously look east and west as well.

I think that the issue here is about the need to move away from solving problems on an ad hoc basis. For example, we are sorting out the issue with the cancer unit in Derry, which you know quite well, and are dealing with it as a discrete issue. It would be much better if we were talking about a whole range of issues that are materially helpful to us. When people live close to the boundary of a jurisdiction, and that jurisdiction does not work in the same way in their day-to-day life, it is not a political deal for them. They will travel to wherever they have to travel.

The Minister has been supportive and has said quite straightforwardly that it is about doing the right thing for people. So, I am content that we will be following through on that by doing whatever is right for the people.

Ms Boyle:

Thank you for the presentation. Following on from what Mark said; we all acknowledge that this is not just about cuts — although that may be the public perception — but about improving quality of services for the individual. I know that most members were out with meals on wheels in their constituencies over the summer and were working with elderly people as well as those who care for them. Under the current system, a home-help visit lasts only 15 minutes. I know that that is a big issue in my area. I was just wondering what the outcome of the review will be for those people who are in most need of care in their homes. John, earlier you mentioned that that could have a damaging effect on people in rural areas.

On the issue of mental health, you spoke about getting the right help in the right place at the right time. I know that we have long waiting lists for specialised help in mental health. I suppose that that is one of the reasons why a lot of young people end up in mental health institutions. Again, how will the review address the waiting list for people with mental health issues?

Mr Compton:

I will say two things. First, although we are doing the review and are doing it well, I do not think that it would be reasonable to leave anybody with the view that it is a panacea and that all the complexities and difficulties that we are dealing with will disappear as a result of it. It is important to say that. It is about a better approach.

Secondly, the issue is about personalised care and what that means specifically. To me, it means — the panel seems to be reflecting this — giving individuals, or their families, greater control over their care and answering the question, "What makes your life work?" That involves us finding a different way of dealing with local communities and supporting them to enable those things to occur. Those are fine words. However, we are working through some specifics that will actually provide something specific and different. Although a lot of people get absolutely tremendous support at home, there are issues that need to be sorted out. If we are to respond to the situation by enabling people to live at home, which is what they tell us they want overwhelmingly, or as close to home as possible, we will have to flip what we do to make that real. If that is our real commitment, we have to think about it very differently. The review is looking at that area very energetically.

Your question about mental health goes back to the previous question. Anywhere in Northern

Ireland where we have only one of something or someone, a one-off, we do not have a resilient service. So, we have to think about the service differently, particularly for some very specialist areas in mental health. Perhaps a wider jurisdiction arrangement would work more successfully for us. That is the attraction of having a much more structured look at those things. Where there is a one-off, we become very dependent on a small group of individuals, and when one of those individuals retires, moves or leave, we have a difficulty. The notion that with a population of 1·8 million we can solve all those problems by ourselves will always be inherently fraught with some difficulty. So we need to think about it in a slightly different way. That is the approach. Mental health services and some of the acute services are driving the real thinking about that.

Mr Brady:
Thanks for the presentation. I want to continue the theme of elderly people. Perhaps I should declare an interest, as I am galloping towards old age myself.

John, it seems that one of the biggest challenges facing the health service is proper provision for elderly people. By 2020, our elderly population will have doubled, and, by 2026, one in five people here will be over 65 years of age. You mentioned people living longer, which is true, but they are not necessarily living more healthily. Preventative care is probably going to be a huge issue.

You mentioned social isolation and malnutrition. In the Southern Trust area, provision of community meals went down by 38% between 2007 and 2010, from 920-odd meals to just over 500. Kieran mentioned going out with the people who deliver the meals, and I have also gone out with them in the Armagh area. The absence of community meals contributes to social isolation. The delivery drivers also help to prevent difficulties. For instance, if a meal from the previous day is still in a fridge or an elderly person does not answer the door, the drivers have some contact with that person. That will be a big problem if community meals are reduced further, and it must be properly addressed. If proper services are not provided, the issue will get bigger and more expensive, because relatively large sums of money could be saved by keeping someone out of hospital.

Disability has not been mentioned. My constituency of Newry and Armagh has one of the highest incidences of MS in the world. That has been documented, and the Mayo Clinic and other venerable institutions have been researching the issue for as long as 30 or 40 years.

Physiotherapy is beneficial for MS, but physiotherapists who retire, leave, and so on, are not being replaced. People who are benefiting from physiotherapy will have to go into acute care in the relatively near future. Again, the issue is prevention. All those issues should be factored in.

John mentioned housing, which is an overarching issue. This morning in Newry, I visited some new houses that have just been built by a housing association, which has incorporated lifelong features. For instance, if a floor-to-ceiling lift is needed in the future, provision has been made so that the ceilings do not need to be taken out. There are also showers that can be used as disabled showers in the future, solar panels and recyclable rainwater. That is a cross-cutting issue and requires joined-up government. I presume that you will also be looking at those issues.

Mr Compton:
You have articulated why we have to undertake the review. Our model of care is not delivering what we want it to deliver. The model of care was designed at a point when the proportion of older people was lower. As we try to make that model of care work and as those demographic indices change, it starts to creak and break — it does not work. Fundamentally, we have to ask about how we provide care for older people and how to do that slightly differently in response to the fact that there are more older people, more people with dementia and more people who need support because of social isolation. That is at the heart of the review.

The same is true to some extent, although not in the same numbers, with disability. The jargon speaks about "re-enablement": instead of asking people who are disabled what they cannot do, ask what they can do. We have to approach it that way, so the model of care involves looking at issues from that perspective. Answering the question about what makes your life work is not straightforward because it is not the same answer for everybody. Even if someone apparently has the same level of disability or of need as other people, there are other dynamics in that person's life that sometimes make the solution different. That is the approach and the thinking involved.

Mr Brady:
Thanks for that, but it is really —

The Chairperson:

John and the team will be coming back for another evidence session.

Mr Brady:

I just want to make one point. I agree with what you said: the existing model is no longer necessarily fit for purpose. The solution is not a question of patching it up. Obviously, a completely new model will have to be considered. It will be encouraging if that happens. As you said, we will wait and see.

Ms P Bradley:

As I am coming in towards the end of the session, there are very few questions for me to ask. My comments will be more of a statement than anything else. What you said on sustainable service had the most impact on me. No one in Northern Ireland could possibly look at the current health service and say that it is sustainable. No one would be foolish enough to believe that. Therefore, your comments are positive. Everyone around the table will look forward to seeing the outcome of that.

Most members have mentioned elder care. Again, I look forward to hearing about greater control because there have been constraints on that. We need to empower our elder population. They need to have choice. We have discussed helpmates. However, there are many other issues. There should be choice and empowerment. Much of that is taken away when we dictate what people must have or do. I am very encouraged by your comments on that matter.

I am also encouraged that you consulted many people. I have spoken to many people, and I am sure that you were lobbied by many specialties and disciplines. I want to put in another spoke for the Northern Ireland Social Care Council. This morning, it held an event in the Long Gallery at which the Chairperson and I were present. Its representatives talked about social care being the cornerstone. I firmly believe that. It is so refreshing that we are not sitting here talking about acute hospitals. We are talking about social care, which is finally being brought to the forefront. A holistic approach is needed, and we need to look at everything. I am encouraged about that so far. I look forward to your findings.

The Chairperson:

Thanks, Paula. I am mindful of time, John, because we have another evidence session. I want to

pick up on a couple of issues. You mentioned people getting the right treatment in the right place at the right time. We will not argue with you about people attending A&E when they really should be elsewhere. However, we have to accept the fact that people get sick 24 hours a day, not just from 9.00 am to 5.00 pm. We need that to be taken into consideration.

Like many members around the table, I see Home-Start as being one of the biggest areas of prevention and the classic, if you like, spend-to-save model. By supporting families early on and giving them the help, advice, and so forth, that they need, many problems down the line are prevented, not only for parents but for their children. The mental health agenda needs to be looked at and factored in.

I am glad that Catherine is here because I wanted to ask her about the dementia strategy. I understand that it is basically ready to go. It might not be fair to bounce you on that, Catherine. You mentioned policies that already exist and that the review takes current policies into consideration. I am worried that the cart is being put before the horse. We need sight of the dementia strategy as quickly as possible so that it can be factored into the review. Mickey mentioned the ageing population. The number of people with dementia will also explode. Unless we put the right steps and training in place for GPs, community nurses and health and social care workers throughout the system, because dementia sufferers —

A mobile phone is ringing and interfering with the recording equipment.

Dementia patients end up in every single element of services. Therefore, everybody needs to be trained in how to deal with people with dementia in a dignified manner. I would like to see publication of the strategy sooner rather than later. It certainly needs to be factored into your review work.

Mr Compton:

I reassure you that we have asked for sight of, if you like, emerging policies, so that if something is about to happen, we take account of it as opposed to what is happening. We have had a conversation in that regard. Working on the strategy will be part of what we do.

The Chairperson:

Perhaps we can bring the dementia strategy back to the Department through either you, Catherine,

or Gillian to find out where it is.

Ms Daly:

Yes, absolutely. You are right. I do not know the exact details on the strategy. I think that it is due to go to consultation very shortly. We engage regularly with John, Pamela and the review team on all aspects of the review. A big part of that is ensuring that there is proper cognisance of all aspects of policy throughout the strategic framework.

The Chairperson:

Thank you very much, John, Pamela and Catherine for coming in. As I said, we are having another evidence session later on. However, you have a good flavour of members' views and the areas that we would like to be prioritised. We have met quite a number of people over the past weeks. There are issues such as early intervention and self-referrals, and there are ways to work that cut out the middleman or the middlewoman to ensure a better pathway for people so that they do not need to take as much time off work, get back to work more quickly and feel that they have received a service that meets their needs.

Mr Compton:

Thank you for the opportunity to meet this afternoon. We will keep you advised of all the events. We will be delighted to talk to anybody at any point. Please get in touch with us if there are issues.

The Chairperson:

Thanks a million, John.