Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Health and Social Care Review

1 February 2012

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 Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Ms Pam Lewis
Mr Kieran McCarthy
Ms Sue Ramsey

Witnesses:

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

The Chairperson: Minister, you are very welcome. Andrew and John, it is good to see you again. Members have been provided with a briefing paper from the Department. The health and social care review is a big piece of work, and we are keen to stay as engaged as we can throughout, as you analyse the consultation and feedback so far. The Minister is going to make a short presentation and then we will take questions from members.

Mr Poots (The Minister of Health, Social Services and Public Safety): Madam Chairperson, unfortunately you were indisposed yesterday. I trust that you will make a quick recovery. We covered the pseudomonas issue quite extensively. We have passed forward the terms of reference to the Committee — I hope that you have got them.

The Chairperson: No, I have not got the terms of reference yet.

Mr Poots: I had asked that you get them. Do you want me to give you the terms of reference now?

The Chairperson: If you leave them with us, that would be helpful. We will not go into it today; if we start, we will never be done.

Mr Poots: We are going to meet you on 15 February in any event. However, I want the Committee to get those at an early point.

Thank you again for the invitation. On this occasion, I am here to update the Committee on the review of health and social care services in Northern Ireland, 'Transforming Your Care'. When I last met the Committee, on 14 December, it was the day after I had made a statement to the Assembly announcing the publication of the review team's proposals. Since that Committee meeting, we have had a take-note debate in the Assembly on the proposals. As I said in my statement and again during the debate, what is being presented through the review's proposals is a major change to our health and social care services, but it is change that is long overdue. It is crucial that we get it right. I have been encouraged by the broad support given to the review report on the Floor of the House and, indeed, from across the sector.

Designing and delivering a new model for health and social care services, one that is built around patient needs, will require engagement with patients and front line providers. So, before we embark on that phase, we need to ensure that everyone is clear on the intentions behind the proposals in the review. I am committed to ensuring that we have an open and transparent process as we move forward. It is important that there is a shared understanding on the solutions and how they should be best implemented.

Following the publication of the report, my Department has been assessing the proposals and how they would be taken forward by the Regional Health and Social Care Board (HSC) and others. That is an essential aspect of the overall process and will allow us to consider the potential implications, how proposals could be best managed and progressed and the interrelationships between them. I cannot say, at this point, whether we will end up implementing each and every proposal in the ways described in the report. Clearly, much work needs to be done now, with a process of engagement with the sector and others. What I can say is that we need to put in place a new model of care as presented in the report if we are to provide safe, resilient and sustainable services for the long term. The model is fully explained in the report and outlined in the background briefing paper, which has already been provided to the Committee.

The review challenges us to look at how we can improve service delivery and structure services around the needs of patients through more effective integrated services with a greater emphasis on delivery in the primary care and community care settings. We have a real opportunity to get the new integrated model right. It is important that changes of the magnitude being proposed are planned and managed in a co-ordinated way and that the delivery of health and social care services retains the confidence of patients and healthcare providers. The last thing that I, or any of us, want is to destabilise the service while we are implementing change. The review team also recognises that, and I support the proposed timeline of five years to implement the change. That is certainly not to say that it will be 2017 before we see any of the benefits of the review. There are some proposals in the review that should be able to be advanced now. Others will require more time to develop, and in some cases we will need to carefully plan the extent of the change that is required, as it is often complex.

There will be engagement across the sector with staff and the public as necessary regarding proposals to significantly change services in their areas. Taking that forward will require effective programme management and governance arrangements to be put in place, which is a priority. The details of those are being developed, and I want to have those arrangements established and in place in the next few days. It will involve the setting up of a strategic programme board, chaired by Andrew McCormick as permanent secretary of the Department, which will report directly and regularly to me. The programme board will oversee the progress on the various work streams and be supported in its work by a regional quality assurance group and an expert panel. That is my first priority, as it will be important going forward to have strong governance and oversight arrangements in place.

One of the first things I want the programme board to do is to help provide clarity and direction to the local commissioning groups (LCGs) so that they can commence the development of the population plans for each of their areas, working with their local trusts. Population plans will set out specific changes to be taken forward to meet needs within a LCG area and will take account of the principles and criteria set out in the review. In developing population plans, LCGs and trusts will engage with local communities, councils and others to ensure that there is a full representation of views in the

development of the plans. The production of the population plans will be a major undertaking in the coming months and will need to take into account the criteria set out in the review and the relevant proposals for change contained within.

Implementation of the review cannot be carried out in isolation, and the work will be linked directly to the work for the commissioning plan in 2012-13 and the action needed in all parts of the HSC to deliver the savings required by the budget. Work is in hand to ensure that the service delivers cost savings of at least 4% in 2012-13, both to balance the cash budget and to absorb the ever-growing demands on the service. There were a number of proposals in the review that, I believe, can and should be progressed sooner rather than later. I feel that we can make progress on areas of work that have already commenced and that have been endorsed by the review as supporting the future model. I would like to see the establishment of the integrated care partnerships (ICPs) get under way, building on the benefits of the primary care partnerships (PCPs). The ICPs will have an important role in supporting the delivery of a number of the review's proposals.

There are also several proposals in the review on which I feel that early progress can and should now be made, consistent with the longer term direction. They include maximising the opportunities brought about from telehealth for patients with long-term conditions — the new Telemonitoring Northern Ireland service is already being rolled out — and promoting mental health and well-being with a particular emphasis on reducing the rates of suicide among young men. We need to consider the detailed work required for the other proposed changes and the priorities of each to ensure that we deliver the model of integrated care presented in the review. I would welcome the Committee's comments on the review and the next steps.

Mr McCarthy: You mentioned the work of the LCGs. We have just had a presentation from the British Medical Association (BMA), and its representatives were talking about replacing the LCGs. I am a bit confused. What is the story there?

The Chairperson: Kieran, I do not think they said that they wanted to replace the LCGs.

Mr McCarthy: I am looking at the document, which states: "LCGs should be replaced". I took it up with Mr Black. Are you saying that LCGs should not be replaced?

Mr Poots: I would say that there should be a greater emphasis on local commissioning and on empowering local communities in the process of commissioning. One of the problems that we currently encounter is that the trusts were up and running before the commissioning groups were up and running and, as a consequence, the commissioning groups have not been able to show their teeth to the extent that I would like them to be able to. Far from replacing LCGs, I want to see them exercising more of the power that has been invested in them.

Mr McCarthy: That is a good answer; thanks very much indeed. I welcome the reference to the developments for carers in the review chapter on health and social care for older people. Can you assure us that the needs of carers, who do such a tremendous job in the community, will be adequately resourced, that carers' voices will be heard and that independent advocacy will be easily accessible? I ask because many carers have described their despair at the complexities and inconsistencies of current care packages and the bureaucracy of the financial system, including direct payments.

Mr Poots: There are a few things there, and I thank Mr McCarthy for the question. I was with carers in Omagh today, and we celebrated the work that carers do. I acknowledge to the Committee the essential role of carers. We, as government, could never hope to replace that role or afford to pay for it. Just because carers do their work for love and affection and because of a friendship does not mean that they should be used and abused. An awful lot of their work is done purely out of kindness to a person for whom they have a lot of love and affection. We, as a Department, need to respond to their needs. We need to look at how carers get information. We have established a website in the Department that gives out that information. It is always being updated. Hopefully, it will enable carers to better access support services.

We will also look to the trusts to meet carers and identify their individual needs and the needs of the person for whom they care. The report sees carers as being equal partners in the care that is provided. What a doctor or a physiotherapist says does not have to be done exactly if the carer is in conflict with them. The carer's views are very important because they work with the person day and daily, and they best know the needs of the individual. Although others may have the medical qualifications, we need to ensure that the voice of the carer is heard during the process.

Respite, of course, is something that carers always complain about. It is important. I suspect that it may come up later when we deal with the residential home places issues. Respite is an area of major importance. You queried direct payments, which were mentioned in the 'Transforming Your Care' report. Perhaps, John, you want to respond to that.

Mr John Compton (Regional Health and Social Care Board): Thank you; I am delighted to do so. Much of what you have referenced is in the report as a direct response to what the review team heard when it was out and about. The objective of the exercise is to make it simpler for older people, their carers and their relatives to be able to use services and to get to a position in which the direct payment system is less cumbersome. We understand that it is quite cumbersome at the moment and that people are sometimes put off because of that. All of that is part of what is intended with the review: changes will be made so that carers are much more centrally involved in the decisions that pertain to their relatives. The system will become simpler to use and understand.

Mr McCarthy: Thanks very much. I am delighted to hear what the Minister and John said about carers. They play an enormous role, and the Minister has acknowledged that.

Mr Wells: Obviously, we are at a very early stage. I have one minor question, then something wider. You propose 17 integrated care partnerships. If an individual GP or a group of GPs did not play ball, as it were, and wished to continue operating as islands, is there a mechanism to enforce the proposal?

Mr Compton: First, the decision to have 17 integrated care partnerships followed a lot of discussion with the general practitioner fraternity about how best to organise them. There was no prescription, if you like, applied right across Northern Ireland saying, "You must have this kind of number". Each LCG area was allowed to design the number of integrated care partnerships that would work effectively in its area and, therefore, avoid the issue of potential resistance, which you raised. So there are different numbers in each of the geographical areas. I think that is quite right, because they need to be local and to reflect a local perspective. That is the first reason: they are organised in the way that the general practitioners wanted them to be organised.

Secondly, I certainly have not heard from any of the major participants in the general practitioner fraternity about any objection to the integrated care partnerships or the involvement of general practice. However, it may the case that some individuals object. Certainly, during our conversations when preparing the review, no resistance or objection was presented to us. If someone did not want to be part of it, for whatever reason, the challenge would be quite substantial because, remember, the integrated care partnerships are not only about the provision of service for individuals but about the governance and quality of care currently received by and provided to individuals. One of the reasons for general practitioners working with each other in this affiliated way is to improve the quality of patient care. I certainly have never heard any of the general practitioners say that that issue is not of central importance to them. I can say to you today that I am not aware of anyone who is not prepared to work with the integrated care partnerships.

Mr Wells: On a wider issue, I have been genuinely surprised about the lack of public comment to date on your report. Over the Christmas holidays, I was expecting to be overwhelmed with letters, emails and phone calls from people concerned about it. I suspect that that was probably due to the report's timing, in that people's minds were on other things. Are you certain that the public and service users are sufficiently aware of the implications of your report? Are they engaging? I know that you were in Newry the other night, where you spoke at quite a well attended meeting. However, I would have thought that there would be more momentum and interest by now. Are you or the Department doing anything to stimulate greater interest in the report?

Mr Compton: There are two things. The first thing that worked very well in the production of the report was the public communication strategy and the debate that took place through the media about, for example, the changes to be made and issues around those. So I think that there was an elevation of the debate about the future shape of health and social care.

I am personally responding to any requests to speak to people. You are right: I was at Newry and Mourne District Council. I have been to Down District Council and am going to other areas in the not too distant future. My sense of it, from talking to lots of people from the voluntary sector, is that there is a general endorsement of the report itself; there is no major opposition to it. I think that some of that may emerge when we get into the very specific service changes and service designs in local areas. My sense is that people accept that we need to change and plan for the future. I think that the case for change has been well made and that it is difficult to accept the case for leaving it as is.

In respect of the production of plans, the expectation is that there will be consultation with the local areas, the key stakeholders and anyone who wishes to have a say or has a view. We have certainly tried and will always continue to try to not be prescriptive about who we talk to. We will talk to anyone who has an interest.

Mr Poots: I suspect that the report has not drawn the angst that Mr Wells indicated it might have because it is quite reflective of where the population is. For a start, it does not identify hospitals that are to be closed; rather, it identifies changes that may take place in a number of facilities. Again, those changes will be worked through with local communities, in their best interest. Nobody is going in to close down facilities overnight; they will go through proper due process and engage with the community about how best to provide those services in the area. I tend to think that that will also be quite a reflective process.

When the residential home issue takes legs, there will probably be greater local opposition in some instances. When we talked about respite care and other opportunities, I indicated that there will be a number of opportunities for homes that currently operate as residential homes. If they do not get the numbers in the future because our plans work and people are staying in their own homes, we will look to the move from the hospital to the community. For example, at the minute, the only option for GPs going out to visit elderly people is to admit them to hospital. However, perhaps three or four days of care in a residential home setting may be enough to strengthen them and get them back on their feet without their having to be admitted to hospital. Therefore, other opportunities will come forward, and there will need to be a wide-ranging discussion on those issues.

The Chairperson: Is there capacity for GPs to do that? In the previous evidence session, the GPs raised with us the fact that they had met John on his own when they were being consulted as part of the pre-review launch, but they would have preferred to have met the wider team. They gave evidence earlier, and we did not get the impression from them that much attempt had been made to seek their views. Therefore, something like that may sound very good in principle, but if people are already waiting a considerable period for a GP appointment and we are asking GPs to do more home visits, surely that will create cracks in the system and will put further pressure on one of the areas that is working well at the minute.

Mr Poots: I thought that the system worked well previously and has worked less well since Tony Blair did one of the stupidest deals ever possible with GPs in which they were expected to cover fewer hours and get more pay. In my opinion, the out-of-hours system does not work as well as it could, or, indeed, should. As a consequence, that causes other problems in the system.

There was a substantial number of meetings with GPs, and there was a specific meeting in Ballymena at which — John, was it 150?

Mr Compton: Just to answer that, you had a range of general practitioner constituents here. Members of the panel met various elements of the general practice fraternity. We did not deny anybody the opportunity to meet anyone, and we responded to any request that was made to us. General practice was involved in all five clinical meetings, which were handled and sponsored by some of the review team.

We also had specific meetings in Belfast at which there were a range of general practitioners, along with Dr Ian Rutter and Chris Ham, to discuss one or two issues that were pertinent as far as they were concerned. Therefore, there may be some individuals who would have liked to have had more contact and engagement, and we can certainly arrange for continued engagement. That is where we are as far as all that is concerned.

The Chairperson: I do not agree with you, John. When you say "some individuals", that is a bit of a dismissive approach. Those comments came from the chair of the Royal College of General Practitioners, so this is not about one doctor being disgruntled because he was not asked for his view.

Mr Compton: I met the chair of the Royal College of General Practitioners, and he seemed entirely satisfied with the meeting that I had. At no point did he request a further meeting. I also met representatives of the BMA and other organisations, and they asked for further meetings, and those meetings were arranged. Had I been asked for a further meeting, I would have arranged it.

The Chairperson: They had asked to meet the wider panel.

Mr Compton: They did not. I was at the meeting, and I can tell you categorically that I was not asked.

The Chairperson: Well, there are clearly two very different versions of that.

Mr Poots: In any event, Madam Chair, the question that you were asking was whether GPs could refer an elderly person directly to a residential home as opposed to a hospital. The option is currently not available to them, but it is something that we would like to make available to them. Very often, you will get considerably better outcomes in those instances. The point that I was making was that if we are not going to have residential homes in their current form in four or five years' time, that does not inevitably lead to the closure of every residential home. There will be other opportunities, such as providing respite for carers and for individuals who need a bit of extra care for a few days to get them back on their feet, as opposed to their going to hospital.

Ms S Ramsey: I thank the Minister and his colleagues for the briefing. I have a number of points. I agree with you and Jim that this is the start of a process, so it is probably a matter of teasing out some of the issues. It struck me during your presentation that we are looking at reforming the health service to make its future focus more patient-centred. When he came into post, the previous Minister almost claimed to be the first to implement RPA etc. We then found out that there was more money spent on senior and middle management at the time than there was on RPA. I have a wee concern that, although we talk about restructuring the health service to take it back to its core principles, we do not want to find, down the line, that more money is spent on administration or middle and senior managers.

Specifically, I agree with LCGs. I was reminded earlier that I was on this Committee 11 years ago, when there was concern that some GPs would not sign up to a lot of the stuff that was being done. I believe that that was because of faults in some constituencies. Without taking away from the work that some GPs had done in their constituencies, unless everybody signs up to this, good work may be done in one part of an area and not as much in other parts. Jim raised the issue, but will there be legislation to ensure that all GPs and all their surgeries sign up to this?
'Transforming Your Care' is, on reading, is not just a health issue. It is about investing for health, so will you give us your view of where your Executive colleagues fit in with that? It comments on housing, education and roads. Is the Executive with you on this road? Will you do so much, only to find out that other Ministers are not playing their part? The example given of a woman needing her stepson is well and good, but unless the Housing Executive stepped up to the mark, the health service was left with responsibility. We have all faced difficulty when trying to get minor work done on people's homes. It can take months, which has an impact. As Health Minister, where do you sit on that issue?

You talked about pharmacies and a family-like approach to an individual's care. Where does that fit with the minor injuries clinic, which I thought of as a positive step forward to prevent people clogging up the system? I also think that long-term care medicine management is a fantastic idea, but we are told that some of those services may be cut. How does that fit in with the reality on the ground?

Mr Poots: I will deal with the Executive and the minor injuries issue and John will deal with the GPs. There is not legislation to require GPs to sign up. It is voluntary and we need them to work with us on these issues. To some extent, there are means of making life a little more difficult for them if they do not, but let us hope that things do not come to that and that we work as a cohesive team to achieve things.

The Programme for Government specifically refers to the sort of change that we wish to make. I continue to meet other Ministers about a range of issues. For example, I met the Minister of Justice, the Minister for Social Development, the Minister of Education, the Culture, Arts and Leisure Minister and others, including the junior Ministers around children's issues. We liaise on a range of issues, and I have made it clear that, for government to work well, it must work cross-departmentally. We can have no silos or invisible walls; no never-the-twain-shall-meet attitude. We need to ensure that we meet, get our heads round the issues and take our joint responsibilities seriously. It is not about saying, "Well, if I stay back, they will pay for it" and so forth. Let us get our heads around it and see how we can make things work. Very often, if we work together, we will make considerable savings for everyone and get far better outcomes.

Minor injuries were mentioned. The remedies hearing resulting from the judicial review takes place on 7 February. Once that is concluded, I will want to get into dialogue with pharmacists about how they see the future. I do not see pharmacists' futures as being dispensers of drugs where that is their main source of income, so that the more drugs they dispense, the greater their income. I want pharmacists to engage more widely in the whole process of healthcare than is currently the case. Currently, they are decently reimbursed for doing that and are incentivised to dispense drugs as and when they are needed. Far too many drugs are dispensed but are destroyed or binned, and some fall into the wrong hands of drug dealers, and that is not the way forward. There is a different role for pharmacists, and we need to have a sensible and rational engagement about that. I intend to lead that.

John, do you want to say anything further about the GPs?

Mr Compton: I am optimistic that we will work very successfully with the GPs over the coming period, particularly on the long-term management of chronic conditions, which is very important. One of the early planning aspects that we are involved with is the development of the integrated care partnerships, and, in particular, how we can work differently with general practice to provide support in the nursing home sector for older people, but also for those with diabetes. Those are the first two starting positions in that regard, after which it will move on to a range of other chronic conditions. Quite clearly, that is quality care and treatment for the people who are receiving it, and enabling that to happen close to home is what everybody wants. I see that as a very important step forward.

On the minor injuries and accident and emergency side of local commissioning plans, there are five constituent parts to think about. There is a regional trauma centre; a blue-light, emergency-type set-up; urgent care, which is doctor-led; minor injuries; and out-of-hours services, which are led by general practitioners. We will expect commissioning plans to tell us how their populations are going to properly access all the component parts of that service in a way that delivers a good outcome. There is a fair bit of evidence to suggest that, if those pieces of the emergency side of the house work more closely together, the individuals who need them will get to the right place and can be sorted out without waiting times. We want the local commissioning plans to look at the situation from a population perspective.

Ms S Ramsey: So where does your organisation fit in? Will you be made redundant in future if the local commissioning plans are working?

Mr Compton: Well, that will be for others to decide. *[Laughter.]*

The local commissioning groups are formally subgroups of the regional board. There is something about maintaining cohesion and coherence; part of the RPA reform was to get a Northern-Ireland wide perspective. That is where the board would see its role: to establish a framework, along with others, as to how local commissioning groups would organise themselves. It is important that that happens in that way. Often, in the past, that fragmentation has been at the root of some of the difficulties that we have had.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): That is the point that I was going to add before you made your comment, Sue. We have a unique opportunity for integration. There are other parts of the UK that would give their eye teeth to have the opportunity and scope that we have to integrate services. They have very deep silos between social care, with local authorities and the NHS, and they do not integrate very well. There are some very good pilots: Torbay is held up as an example of where that has been tried and work has been done, but they are working uphill. We are working downhill because we have the structures in place. There is a lot to be said for the structural arrangement that is the Health and Social Care Board, because it has the best of both worlds: a local dimension and local power in the form of the LCGs, and regional services. We are not duplicating information functions or financial functions; those are brought together as neatly as possible while maintaining local roots and links to general practice and across the different disciplines.

We are not looking at clinical commissioning groups. In the negotiations in 2006 and 2007 with GPs in Northern Ireland, there was no difficulty at all in securing agreement to local commissioning groups that did not have GPs in a majority. Instead, we have LCGs with GPs, pharmacy, nursing, social care, local government and the voluntary and community sector. That is a different model. As the Minister said earlier, we have yet to fully exploit the opportunity, but it is there and is very real. The best way to move forward is to keep drawing out the opportunity that is there. Individual general practitioners will respond in different ways, and that is not a problem, because they have major responsibilities just to look after the patients. The extent to which they can commit time to the wider functions is different and will vary, and that is totally fine. What we have is a model that is very compelling and can deliver better care.

The Chairperson: Some of us might be made redundant, John, before you are.

Mr Durkan: I thank the Minister, Andrew and John for their presentation and for coming here again today. A point was made about residential care for older people. Everyone will embrace the theory of moving care from institutional settings to community settings. Obviously, there will be a lot of political sensitivities in so doing. If I am not mistaken, the Minister mentioned a period of four to five years. Although we embrace the idea of moving from institutional to home and community settings, that will not be so easy for people who have become institutionalised. What strategy might be applied for dealing with such people who are not yet in need of nursing care?

Mr Poots: A lot of the facilities are not topped up as and when some of the residents move on to nursing care or pass away. Therefore, we have to look at what we do with those facilities. Obviously, if there are more people in the community, there will be a greater requirement for respite care, so a number of those facilities will benefit from having more people coming in for respite care. The run down of numbers that is being applied to residential care homes will happen incrementally over a period of time, and decisions will be made either by the trusts or, indeed, the residential homeowners that are in the private sector as to how best they can respond for the future. If it is an old building that requires a lot of maintenance, they may decide that they do not wish to continue in that facility and look for opportunities. If it is a more modern facility, they may engage with the trusts to provide that respite care for people who require it for short periods of time as opposed to going into hospital. John, do you have any further thoughts?

Mr Compton: The first thing to say is that, although the document talks about a major change in residential care, it is not saying that there will not be residential care. It is about the scale and the proportion of residential care, and, if, looking forward, you take the view that home care, residential care, nursing home care and dementia care are the core components, the demand for residential care is already declining and is anticipated to decline further or to be replaced by housing with care through sheltered housing schemes as such. This is about recognising that there is a change in how people are using those services. The change will have to be handled with enormous sensitivity, because you cannot simply ask people who have moved into those facilities to pack their bags and leave in that regard. When these things have happened and there have been changes in the past, they have been handled with considerable sensitivity for and in reflection of the individual circumstances. I would not expect any less in the future.

The Minister is correct in saying that, at one level, this is about preventing the overuse of hospitals. We know that we overuse hospitals, often for people who are older and might be managed in different ways. There is a whole range of step-up facilities that allow people to go — instead of going into hospital — into respite care facilities and day support facilities, and the document talks about that diversity of service being available. Some of the buildings we have will be properly adaptable to doing that, but some of them will not because of their age or configuration. The older buildings are probably not a very sensible choice for residential care in any event. Again, that is why it is a five-year thing; it is not about rushing, because this is a vulnerable group of people for whom you would need to apply considerable sensitivity in handling the change. However, I am not of the view that that could not be handled throughout the period and beyond.

Mr Poots: If there is a home with 30 residents and its capacity was for 40 residents, you would not be turfing 30 residents out. You would top that home up with respite care. It is only when the numbers drop right down that you would look at making changes. This is not about putting elderly people out of accommodation in mass numbers across the piece; it is about dealing with this sensitively and sensibly in order to get a better outcome in the bigger picture.

Mr Durkan: I am glad to hear that residential care is not going to be done away with entirely, because I can envisage in the future a possible increase in demand for residential care, particularly if you look at the change in family profiles. People are not having as many children and there are more single-parent families and so on, so there will not be as many offspring to care for their older parents at home or to assist in their care at home. I think there may be a greater reliance on the state to provide care. Although there has been a decline in the demand for residential care, has there been an increase in the demand for nursing home care, which was identified as being three and a half times as much per head of the population, compared with the rest of —

Mr Compton: There is an increase in demand in nursing home care. Again, the review indicated that and mentioned some policy changes that would reside first and foremost in the bailiwick of the Department, including price regulation and that sort of stuff. That came into the recommendation. One issue that we have at the minute is that we have a marketplace in nursing home care that sometimes works to your advantage and sometimes does not. We have capacity issues whereby, in one area, there is significant over-provision, and in another area, there may be significant under-provision. The suggestion in the review was that we get that into a bit more of a coherent and ordered pattern of provision so that we do not end up with vulnerabilities, fragility and financial difficulties for those who are providing that service, whether that be a statutory or private sector side.

The short answer is more pressure for nursing home care, more pressure for specialist care for those with dementia, fewer referrals, less pressure on residential care and more pressure on home care, which is entirely consistent with what is said in the document. There are also new models of service in that arena, so the step-up, step-down facility, enabling people to come out of hospital more quickly, preventing people going into hospital, and supported by the integrated care partnerships, is what this is heading towards. We will also be looking at dementia care in a slightly different way, because we know, again from the demographics, the numbers that are involved in that sort of requirement. It is about remodelling what we have in our current sector to respond to the actual need.

One thing we have less need for today and will continue to have less need for is residential care, because residential care now is often replaced by housing with care, which is a better choice. It responds to the issues of isolation that are sometimes referred to as a reason why people go into residential care. Those who live in housing-with-care situations are able to live close to other people, and, therefore, avoid social isolation. They do not live in institutions per se and have much more personal independence and dignity in where they reside.

Mr Durkan: Thank you. I have one more question. Is it conceivable that, in an area in which there is under-provision or not enough capacity in nursing homes, and I know an area like that, work could done with residential homes to enable them to provide nursing care?

Mr Compton: That is a possibility. The real issue will be in asking the local planning groups to talk about the needs of the older people in their planning areas and how those might be best addressed. There is no proscription to doing anything. It is about responding to need, and finding the most

appropriate and best way to respond to nursing home provision in a particular area. It will be for local groups to decide what model they want in their areas. The framework is clear, but the detail of the framework will reflect local circumstances and solutions. The framework is in place to keep Northern Ireland consistent from a central point of view. However, it will allow for local expression in local areas. Local arrangements will decide the best way to respond.

Mr Poots: Minimum room sizes and so forth will probably preclude the use of many of the older residential homes. It would not stack up financially to make the sort of changes that would be required to enable them to switch to nursing home care. We want nursing home care provided in houses and be built in and so forth to improve the care of people with a lot of mobility problems.

Mr Durkan: I like John's emphasis and repetition of the word local. If people must ultimately go into nursing homes, those homes should be local to them.

Mr Compton: Absolutely.

Mr Brady: Thanks for your presentation. Jim made the point that he was surprised at the initial public reaction to the report. However, I was at the meeting in Newry on Monday, and I am sure that you went home with Daisy Hill Hospital ringing in your ears. That hospital was singled out unnecessarily by sections of the media. I think that you did your best on Monday to allay fears about a leak and about the media being aware of something that the people in the room were not.
The report specifically mentions the voluntary and community sector playing a much greater role in providing services and improving the delivery of services. There is a strong community infrastructure in my constituency, and some of the groups provide respite care to a greater or lesser extent. Minister, you talked about cross-departmental co-operation. The Department for Social Development provides funding for a lot of those groups, specifically through supporting people, neighbourhood renewal and the targeting of areas of need and deprivation. Will there be cross-departmental interaction and funding to provide for and increase the role that is played by those groups, particularly and specifically in the provision of the services that are required?

This all ties in with the ethos of care in the community. That care is being provided, but a lot more could be done with proper funding. The infrastructure in many areas is there and people do a good job. However, they are constantly chasing their tail for funding, and that takes away from the work that they could do. As someone who worked in the voluntary sector for a long time, I am very aware of that. I think that this is a good opportunity to enhance that cross-departmental role, particularly in the provision of those services.

Mr Poots: I would certainly encourage a greater cross-departmental role. The point that you made about the Department for Social Development and my Department is absolutely true. Very often, we need to adapt homes for those who have had strokes or some other life-changing health incidents, and, as a consequence, we need to have pretty quick responses. As Committee members will know, far too often we are too slow at getting occupational therapists out and reports completed. We are also often too slow at getting the Department for Social Development to implement things. As a consequence, the waiting time for that person to get back into their own home is delayed significantly. We need to do more on that front, and that is an area that I want to explore.

Dr McCormick: That is exactly the right direction to take. Discussions are ongoing with other Departments to seek new ways to handle this in what is obviously a very difficult and challenging financial situation. We must look creatively at the nature of the partnership arrangements and the opportunities for good and open procurement processes that maximise the opportunity for local providers from the voluntary and community sector to contribute to the service development context that we are in. It is very important.

Mr Brady: It is a simple solution in some ways. I went to the opening of seven new houses in Derrybeg estate in Newry that were provided by one of the housing associations. Derrybeg is one of the oldest estates in Newry, but it is lifelong housing, and all the infrastructure is already there. For instance, there are columns that you can lift out of the ceiling if you need a floor-to-ceiling lift. There are walk-in-showers already built in. Rainwater and water from the cisterns is recycled.

From talking to the housing association that provided the houses, I am aware that those houses are not that much more expensive. However, it is hugely expensive to adapt an older house. The Department for Social Development is the provider of social housing through the housing associations. That is an area that could be looked at. It goes back to the whole ethos of keeping people in the community. I have to say that those houses are relatively inexpensive but very impressive, even in their heating and all that. It is inexpensive but would solve some of the problems of fuel poverty and so on. It is an opportunity to be innovative and to look at those areas holistically with other Departments.

The Chairperson: It took some a long time to catch up. It is very frustrating, as all of us know as constituency reps.

Mr Dunne: A lot of it has been covered already. Will you give us an update of where the implementation plan is at the moment? There are details in the report, and the plan is obviously headed up by the Minister through the Department and the programme board. Has the programme board been established?

Dr McCormick: We are in the process of contacting individuals to ensure that the right roles are being fulfilled at every level and that different aspects of planning are drawn together. I will touch on the dimensions of planning in the next session as well, if that is in order.

A financial plan is needed to secure the full delivery of savings in the three years ahead. The aspects of the quality strategy and the public health planning all need to be brought together, alongside the proper assessment and development of everything in 'Transforming Your Care'. The Minister referred to the strategic programme board that I will chair. There will also be more detailed implementation. It is not for the Department to get involved in the detail of the commissioning of services. That is entirely for John to lead and for the board. The structures that will be established and put in place will ensure a full recognition of statutory roles.

We recognise and have discussed at length over the last few weeks that this is a much bigger task than the day job. We need specific arrangements to ensure that there are well-managed, well-governed processes that make this work. We have given it a lot of thought. We want to ensure that there is a full and effective process that it is fully accountable to the Minister. We want to handle those things properly and show that progress is being made and that the plans at local level that are at the heart of it are brought together. John and his team oversee all that. It is in place; it is just not quite populated with individuals. We have not yet had the first meeting of the programme board, but those things are being geared up and got ready because the time is now —

Mr Dunne: The clinical forum has been established.

Dr McCormick: We are using wider language to ensure that it is seen that there is a very important role for doctors in that process. Part of where that came from in John's report was the need to guarantee that whatever is put in place will be safe and sustainable. The criteria for service change are very important.

However, we are an integrated health and social care system, so I think we are tending towards a phrase like "expert group" or "expert panel". It will have an advisory role to the commissioners. It is the commissioners' responsibility to commission services that are safe and of high quality. An extra dimension, in the form of a region-wide group advising them on those issues, will add significantly to the process by providing a special context of good advice.

John and I have spoken separately to David Sissling, who is my counterpart in Wales. There is a clinical forum there that has proved very effective in helping the service lead and manage change and help secure public confidence that what is being done and what emerges from the planning process has sound professional advice in it. That is a very important dimension.

Mr Compton: I have something to add, because I know this was raised previously. It will not be a hoop that people will have to jump through or something with a veto. It is there to provide advice, both at regional and local level. When people are helping to shape local services, they will have access to

experts who will be helpful in debating and discussing the issue, giving an opinion on where we are going and accessing other expertise, if it is not immediately available. That is the plan. Use of the phrase "expert panel" will signal that this is not exclusively for doctors; it will also have to deal with issues involving nurses, pharmacists, general practitioners and social workers.

Mr Dunne: This will be the clinical forum.

Mr Compton: That is right.

Mr Dunne: What about your role? Do you have a role in the implementation?

Mr Compton: As Andrew has said, as we have agreed and as I understand it, the board will be asked to do the lead service transition operational side of things. So we will be responsible for the production of the board corporate — the production of the local population plans — and aggregating that and putting it into some sort of shape. You will be talking later about the direction commissioning plan. Through all of that process, we will have the lead role instrumentally in the transactions that take place to make that happen.

We will also have a very strong role in the integrated care partnerships with the general practitioners. In simple terms, the service side of the house will be channelled through the board. There is a range of things, but the overall co-ordination will be channelled through the Department. Such matters as legislation, among others, would, rightly, sit there, and we will be working closely and reporting and relating to the Minister as necessary and/or appropriate.

The Chairperson: I want to follow up on Mark's point about residential homes. I was glad to hear you say that the issue would be handled with enormous sensitivity. A number of years ago, a residential home in my constituency took in a certain number of people for respite; there was a particular amount of respite beds, along with long-term beds. However, those respite beds were then closed, and we were told that it was unsettling for the long-term clients to have strangers come in from their homes on an ongoing basis, and that the respite along with the permanent did not work. That is relevant to how we look at some of the homes and how we manage them. I hope it will be done in a way that is sensitive and that there is not an ongoing turnaround of people. If you live there permanently, you need to be treated with sensitivity. I am concerned about that.

We very much welcome the shift away from putting people into residential homes, but, at the same time, I am concerned about the people who are there. That will be a concern that is shared by many people in the Committee. If the number of residents in a home goes down to four, five or six people and the home is no longer viable, how will those people be dealt with? Where will they go? How much work will be done with the families to try to rehome them? I know that it is a five-year plan, but some of the people who are already institutionalised will live for longer than five years. That needs to be taken into consideration. Paragraph 2.2 of your paper states that:

"critical clinical staff would be employed to work in a hospital system. They would therefore be a resource for each population working as necessary across hospital services and within community settings as appropriate."

Does that mean that hospital staff will be recruited on a rotational basis? Does it mean that there will be a different management structure and that they will not be tied to a particular hospital but will go where there is need?

Mr Compton: I will give you a specific example. If the Southern Trust were to appoint a consultant to any specialist post, they would be appointed to work in the Southern Trust, not in either Daisy Hill or Craigavon. In fact, as this is worked through, they may be required to work in both places. The review recognised that, if you simply leave people entrapped and working in a narrow way like that, you disable the ability to establish a network. In fact, over the past number of years, it has become quite commonplace for specialist clinical nursing and specialist social work staff to work across a range of facilities. The report recommended that, in future, we recruit people in the clear knowledge that that is the case, so that we do not come across any HR problems that might emerge where someone thinks

that they have a job that involves them working in one place, not another. That is already under way, and a specific example of where it occurs is the Southern Trust area.

The Chairperson: Does that mean that other doctors who are employed will have their contracts changed?

Mr Compton: As part of any proposal to make transitions or changes to services, such as moving a service from one place to another, you get into the whole area of the transfer of undertakings. People are doing a job, and you have to handle all of that correctly and properly. I do not believe that there will be any particular difficulty in doing that. Going forward, we will be employing people to work in a way that enables that network to be established and to deliver. If changes are made, the normal negotiation processes on the human resources side of the debate will pertain to individuals and will take their normal course.

The Chairperson: Paragraph 2.5 talks about a shift of 5%, or £83 million, from the hospital services budget to other services. In the current year, the acute services budget was increased by £57 million compared with 2010-11. Is that just moving around £25 million?

Mr Compton: No.

Mr Poots: We are looking at a 2% reduction, so, whatever size the cake might be, the overall slice of the cake will be 2% less for hospital provision. The primary care budget will go up by 0·5%, and community care will increase by 0·5%. There will be a direct shift in the percentage funding from the hospitals to the primary and community care sector.

The Chairperson: The shift of funding in your paper, Minister, is 5%, but, even so, it looks like there might be —

Mr Compton: What might be causing the confusion is the baseline year in which the percentages are used, and running that forward using the budget period over the three-year period shows you that. There is planned money coming into the system, but we took the baseline year, so it is actually about the money coming out of hospital systems. We have looked at average length of stay and the number of hospital beds, and all of this is designed to say that, because we do not have the alternative services in place, we use hospitals and spend that £83 million in them. Over time, that £83 million would come out of the hospitals budget and be re-ascribed to areas such as mental health, primary care, and older people's and children's services. The document explains that by detailing the numbers.

The Chairperson: The fact that it is in your paper made me wonder whether it was really a shift out of acute services or whether it was a bit of — I will not say creative accounting to the three of you, but you know what I mean.

Minister, you mentioned minor injuries units. We spoke about that briefly at the meeting in July last year when the changes were being made at Lagan Valley Hospital. The Southern Trust area has a very successful minor injuries unit and there is a consultation on reconfiguring that service and the length of time it is open. Part of the success in the Southern Trust area with regard to trolley waits and its management of its emergency department was due to the fact that there was a minor injuries unit where people with minor injuries could go and not clog up A&E and create a problem in the acute sector. That is a very valuable service. However, it is planned to reduce that. It is out to consultation and no decision has been taken. However, it is important that there is confidence and that the unit is open at times that it is likely to be busy.

Minister, you have been very patient and I apologise for keeping you waiting at the beginning of this session. There is ongoing work around this report. It is the most far-reaching report that we will have to deal with in this term. The last time you were in with us there were a few surprises the next day, so I am just asking whether there are any surprises or anything that is likely to make the news tomorrow that we may have liked a heads-up on today. John, are you sure?

Mr Poots: I would love to know what is making the news tomorrow, to be honest, and be better prepared for it. *[Laughter.]* You never know in this game.

The Chairperson: The day after you were last here, we were dealing with the Cabinet Office inquiry and all that. The button seemed to have been pressed within minutes of you leaving here that afternoon.

Mr Compton: I do understand that issue but I suppose it was not raised because it had been at a public board meeting. I would need to go back over the dates in my head but we discussed the matter publicly at our board meeting in December and we sent you the board paper for our January meeting because we thought that someone would raise another issue. From the board's point of view, therefore, all that was in the public domain since we commenced the process, and that is as it should be.

The Chairperson: It is just that the three of you were in on the Wednesday and the next day the questionnaires went out to 200 members of staff. A bit of a heads-up would have been helpful because that is an issue that some of us are very vexed about. I just wanted to make the point that this Committee would like to be kept abreast of what is happening if there is any breaking news.

Mr Brady: Going back to the voluntary and community sector, Minister, the funding for schemes such as Home-Start, which is engaged in preventative work for young families, is being cut along with that for some other groups. The timeline for the outworkings of the report is five years. If those groups are affected now and people have to move on, you will lose all that experience. That is something to keep in mind because all that experience may well be lost, and that is also the case with other groups whose funding is rapidly diminishing. They are often not given the recognition that they deserve, but they play an important role. We need to be aware of that.

Mr Poots: I am glad that you asked that. We have reinstated the funding to Home-Start in the Down area. There is a request in from the Ards group and, I think, the Armagh and Dungannon one. The rest of the Home-Starts, as I understand it, are financially viable this year. We are looking at those requests and seeing whether we can take them through to April next year because there is a possibility of them bidding for funding to the social investment fund and the social protection fund.

You touched on an issue that I discussed with Andrew a number of times and I would like the Committee to give it some thought. Trusts dispense funding to various voluntary sector organisations. However, I see an issue in that the Western Trust may decide to give funding to some organisations and not to others. The Northern Trust may give to different organisations, and there may be crossover. The Belfast Trust may cross over again, but might also provide funding to organisations that do not get funding from the other trusts. You end up with a situation where voluntary organisations may be funded by three trusts but are providing a good service to the community across all of Northern Ireland, although they are not really supposed to use the money from one trust elsewhere. I wonder whether we would be better drawing back the money that the trusts use for that funding and dispensing it through the HSC, which John is responsible for, and the Public Health Agency (PHA), which dispenses money Province-wide. Another school of thought is that the trusts could respond at a more local level, and the LCGs and so forth could have more input.

Perhaps Committee members will give me their thoughts on that, because it is a situation that I am very uncomfortable with. Even today, Action on Hearing Loss was complaining that the Western Trust gives it funding but the Northern Trust does not. I think the Northern Trust is the only trust that does not give it funding. That is another example of people potentially being discriminated against in one part of Northern Ireland, as those who receive support for hearing loss in the Northern Trust area are not receiving the same help as their counterparts in the rest of Northern Ireland. Perhaps the Committee will give some thought to that. I would appreciate your feedback.

The Chairperson: Minister, I hear what you are saying. Another example is Positive Futures, which operates in the Western Trust area and is having a huge impact on families that have children with autism. That is happening in the Western Trust area; my constituency covers the Western Trust and Southern Trust areas. There are families who would benefit from that service not just across my constituency but across the North.

If we brought the allocation of funding back to the centre, you could find that some services might be withdrawn from people who currently receive them, which would be hugely problematic. This Committee has not had a chance to take a corporate view of the situation. It would be very helpful if a paper were forthcoming on the kind of areas and organisations that you are talking about, the work that they do and who they are benefiting. We would like to have further discussion on that.

My concern would be the creation of a situation in which one LCG decides to prioritise children and young people and another is prioritising the elderly population. The issue is getting a mix that suits across the board, so that nobody feels like they are being discriminated against, but equally people get services that they are crying out for.

Mr Brady: For a lot of voluntary organisations, mainstream funding, not piecemeal funding, has always been the goal. A balance has to be struck, because, although mainstream funding is very desirable, there still has to be some scope for groups that are on the periphery and do very good work but do not necessarily dovetail into that category. That is important. When I worked in the voluntary sector, getting mainstream funding was like trying to find the philosopher's stone; there were all sorts of task forces sent out to find the pot of gold at the end of the rainbow. Unfortunately, the rain stopped and they never managed to find it. However, it is something worth thinking about.

Mr Poots: I will ask Andrew to prepare a paper for the Committee and myself on that. One of the other advantages is that voluntary organisations very often spend an awful lot of time filling out application forms. If groups fill out applications forms to five trusts, the PHA and the HSC, when the source of the funding is the same, a lot of staff time is being consumed in those organisations and in the voluntary sector. Therefore, there would be an efficiency aspect to bringing it together.

However, it is not all advantageous; there are disadvantages to it, which is why I have thrown it out for discourse and some further thoughts. We will prepare a paper, and it might be useful for us to take a look at this issue. If we come to a unified view on it, it would be quite positive.

Ms P Bradley: If you threw this idea out to voluntary groups, they would be screaming, "Yes, let's do that instead." I am being lobbied daily and weekly by groups from Belfast who get the majority of their funding from the Belfast Trust. That funding has been cut radically, and, therefore, their service has been cut radically as well. That is not just the case for voluntary organisations, it is also the case for private sector organisations. The whole ethos of the review is to allow people to live in their home safely. What has been happening lately is going against that. I think that there should be a review looking at how the funding is handed out and the differences between trusts, in not only the voluntary sector but the private sector.

Mr McCarthy: I was going to raise this under any other business, but I will do it now that the bosses are here. It has come to my attention that the contribution from the Health Department to the family fund has been cut. The family fund distributes funding to families with disabled youngsters but that has been cut. That news only came to my ears today. It is very worrying, because it is very important. Does the Minister know about that?

Mr Poots: No, I did not know about that either.

Mr McCarthy: I was going to ask that we write a letter to the Minister.

The Chairperson: Perhaps there will be an opportunity to do that on the back of tomorrow's evidence session. We will do it when we are better informed of the facts.

Ms Lewis: I welcome the comments by the Minister. I think it is a really good idea to look at that whole area and see what improvements can be made. I recently had a representation from a charity, which I will not name. It was not complaining but told me that a different area of the charity, which was already quids in, got a large amount of money awarded to it, whereas another area of the same charity was scraping around on the floor trying to get pennies together. Anything that you can do to improve that situation and ease the burden in relation to funding applications would be very good.

The Chairperson: Thanks a million, Minister, John and Andrew, for that.