Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

‘Transforming Your Care: A Review of Health and Social Care in Northern Ireland’

14 December 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

'Transforming Your Care: A Review of Health and Social Care in Northern Ireland'

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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
Mr Sam Gardiner
Ms Pam Lewis
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

Mr Edwin Poots	) Minister of Health, Social Services and Public Safety
Dr Andrew McCormick	) Department of Health, Social Services and Public Safety
Mr John Compton	) Health and Social Care Review Team

The Chairperson:

I welcome the Minister of Health, Social Services and Public Safety, Edwin Poots, Dr Andrew McCormick, the permanent secretary of the Department of Health, Social Services and Public

Safety (DHSSPS), and Mr John Compton, the chief executive of the Health and Social Care Board. I advise members that the Minister has indicated that he is available for only an hour. We will try our best to let him away at 2.30 pm. I remind members to keep their questions short, please. I hope that we can get everybody in.

Minister, you are very welcome. You are going to give us a short presentation.

Mr Poots (The Minister of Health, Social Services and Public Safety):
I thank the Chair and the Committee for the invitation to attend today. Members have had the 'Transforming Your Care' report for more than 24 hours, so you have had an opportunity to have a good read of it. We intend to bring a take-note debate to the House in the new year to allow Members outside the Committee for Health, Social Services and Public Safety, and indeed members of the Committee, to engage further in what I believe is an important process. Good engagement will lead to better outputs.

I made my statement in the House yesterday and explained the importance attached to the review. It sets out a compelling case for change and is built on statistical evidence and research, inputs from extensive engagement with stakeholders and a case that has been endorsed by the panel of independent experts.

The review sets out 11 reasons for change and 12 principles for change. Few could disagree with the reasons and principles. They might not always like the outcomes, but our aim is to improve patient care and deliver better outcomes so we need to ensure that patients are treated in the right place at the right time by the right people and reduce over-reliance on hospital care.

If we want to deliver the best outcomes for everyone and to maintain the highest levels of quality and safety in service provision, under the principle of health services being free at the point of need, our full range of health and social care services are unsustainable in their present form. The review proposals represent a radical change to the way our health and social care services are delivered. That change is long overdue.

The review presents proposals for a future model for integrated health and social care. The

proposed model, which has been endorsed by the expert panel, is sustainable and should deliver a different, improved and safe service. The model puts individuals, not institutions, at the centre and supports individuals to care for themselves and make good health choices. Health professionals could work together to plan and deliver those services in a much more integrated way, and integrated care partnerships would be set up to join together the full range of health and social care services in their area.

There would be a significant shift from provision of services in hospitals to service in the community, in GP surgeries and closer to home, where it is safe and effective to do that. Services would regard home as the hub and be able to ensure that people can be cared for at home, including at the end of life.

It was perhaps inevitable that much of yesterday's coverage would be about hospital provision, although, as I outlined, the review is about much more than acute care. Indeed, it covers nine other service areas that deserve equal attention. The report is not prescriptive about the number of hospitals; instead, it sets out services that should be available, including services that acute hospitals must be able to provide. The watchwords are: "safe, resilient and sustainable hospitals".

The review anticipates that there will be changes at all hospital sites over a five-year period, with the final functionality based on population needs and the principles and criteria set out in the report. Engagement at local level with local commissioning groups (LCGs) and trusts will inform the services to be provided in each area. The key test for any future service configuration has to be sustainability and resilience in clinical terms.

As I said, the review is about much more than hospitals and contains an assessment of the current position and proposals across a number of key service areas, including provision for older people and those with long-term conditions; improving services for those with physical or learning disabilities; provision for people using mental health services; provision for maternity and child health services; palliative and end-of-life care; and for family and childcare.

The report presents a total of 99 proposals. The proposed changes would require the

development of different skills and capacities. Workforce planning and development is, and will be, a critical building block in ensuring that staff are appropriately trained and confident in their roles for the model of care.

With regard to services for older people, concerns were raised yesterday about the closure of residential homes. I should make it clear that residential care places have been declining, and a shift of resources from residential care to home care is in line with providing greater independence for people at home and introducing new models such as respite care. We need to move our focus from institutions to individuals.

A change in the model of delivery means that there will be a shift in care from hospital settings to the community. There will also be a shift in resources as funds are reallocated in line with service delivery. It is envisaged that by 2014-15, there will be a shift in funding of around 5% or £83 million from the hospital service budget to other services. The review recommends that transitional funding of around £70 million be provided over the next three years to enable the new model of service to be implemented. I recognise the need for some resources to help to support the shift required.

The review team has produced a wide-ranging set of proposals, and in the coming weeks and months, they will need to be translated into more detailed implementation and stakeholder engagement plans, setting out specific changes to be taken forward. The plans will be based on population plans for each area, drawn up by each of the local commissioning groups with the health and social care trusts. The review recommends that plans are drawn up and published by June 2012 and sets a five-year horizon for changing the provision of services. It is inevitable that changes will need to happen at different timescales, reflecting the current position for specific services in localities but all within a coherent framework provided by the review. I also want effective governance arrangements in place for implementation where the review is one of several key strands of work that need to be progressed in a joined-up way. My Department will put in place programme management structures to take those strands forward to ensure an effective whole-system approach to reforming our health and social care system.

We are very happy to take questions. I suspect that John will probably field a lot of them if

they are about the detail of the report. Questions about implementation will probably be answered by Andrew or me.

The Chairperson:

Thanks, Minister. Everybody is on the ball today and nearly all members have indicated that they want to ask questions.

We gave the report a fairly guarded welcome yesterday, before getting into its detail. The longer I had it and the more I hoked through it, the more questions I had. There are certainly some very good things in the report; we accept and acknowledge that.

On the focus on preventative care, proposal 35 states:

"Preventative screening programmes fully in place to ensure the safest possible outcome to pregnancy."

Is that a hint towards group B streptococcus screening?

Mr Poots:

I will ask John to answer that.

Mr John Compton (Health and Social Care Review Team):

Whatever the professional advice is, we will respond to it. If professional advice indicates that a certain form of screening should be introduced, we would obviously move towards its introduction. In the report, we were quite keen to recognise the fact that our prevention and screening programmes, and immunisation, are critical in preventing people becoming unwell. We should be really rigorous in making sure that we follow the best professional advice so that Northern Ireland has full implementation of those issues. There is an ongoing debate about the specific screening that you raised. Our judgements will be determined by the professional advice that comes to us.

The Chairperson:

It is the professional advice that worries me, John, given what we have heard in this Committee.

I do not want to spend any time on that today, but I thought that that was interesting.

I also want to mention human papilloma virus (HPV) screening. I did not notice where that is in the report, but I presume that there will be a wider emphasis on it.

Mr Compton:

It is in there.

The Chairperson:

I am delighted that kinship care got a mention. We will come back to that issue in the new year. I was also glad to see a focus on child and adolescent mental health services (CAMHS). We welcome the report's comments on prevention, primary care and community care. I probably do not speak on behalf of the entire Committee, but I welcome the move towards greater integration and all-Ireland working around the sustainability of services.

Yesterday, the media picked up on the issue of residential homes. It would be interesting to get a bit of clarification on that. I think that I saw the word "substantial" used, but I did not see that all state-owned residential homes were closing. Perhaps you can put some meat on the bones of that. I know that it is a phased five-year strategy, but there needs to be recognition — we talked about this earlier in the week — of the people who perhaps do not have a home to go to and who cannot be accommodated elsewhere, for whom a residential home is their home. There are different reasons why such people should be kept in residential homes, and I hope that there will not be a one-size-fits-all approach to the issue.

I am most interested in the framework for the future — the "roadmap" — to develop the population plan, led by local commissioning groups and supported by health and social care trusts, integrated care partnerships and communities. That is great stuff, but I then find that they are at the bottom rung of the ladder and that that has to be approved by the NI clinical forum, the local commissioning groups, NIMDTA and the Ambulance Service. That then goes up to the Health and Social Care Board for final sign-off. My point — you may have heard it in the media last night — is that a local commissioning group and a local trust could come up with a solution that fits their population size, needs and desires and ticks all the boxes. However, there are two

stages at which that plan could be vetoed. Who exactly will be on the clinical forum and how will that veto work?

Mr Compton:

I will deal with the residential care question first. It is a five-year strategy. The number of people applying for and using residential care has been flatlining or declining in the past number of years. At present, we provide care at home, in residential care and in nursing homes, and care for people with dementia. There has been a change in residential care. A number of residential care facilities now provide respite care alongside, if you like, permanent residency and placements. We expect the number of people requiring such a permanent solution to decline, so we envisage a major change in the residential home infrastructure and what it is used for. The need for respite care and such services is indicated in the report, so it is entirely possible that some of those buildings could be converted, for example, into respite centres.

Given that housing associations have services such as housing-with-care, the actual need for residential care is generally declining. The report reflects that decline and considers how we would invest that money, principally into home care. Nothing dramatic has been planned; no one is going to say to old people who are residents that they must pack their bags because it is time to go. It will happen over a five-year period, and there will be a proper evolution, transfer and change in how residential care is provided in the community.

When people are clear about the definitions of home care, nursing home care and dementia and residential care, I do not think that there will be as much opposition as people expect. Often, people confuse residential and nursing home care as being one and the same thing; they are quite distinct services, and there is a strong emphasis on supporting and improving the nursing home care arrangements at the same time. That is the logic and rationale behind the thinking. By saying that home is the hub and that the principle is to support people at home, individuals entering residential care should, by and large, be able to be avoided. We do not say that that would apply to everybody, but it would apply to the majority. That is what we think about the model development.

The point that you raised about the hospital issue is really a “what and how” argument. It is

important to clarify that. It is not that someone will set an unreasonable test, if that is what is behind the question. It is not that people will come up with a solution and then be set an unreasonable test. Chris Ham and other members of the panel were very strong about the issue. If, from a review point of view, it is specified that one hospital will do one thing and another hospital will do another, all sorts of difficulties will be created. Solutions need to be built from a local area and a local perspective. However, they need to be built on the basis of clinical evidence on the best outcome and what is known about resilience, sustainability and making hospital services safe. I would not expect a sensible plan from a local commissioning group to disregard those matters, so I do not think that there would be any real difficulty or problem in running through other perspectives to get to a solution. Everybody is working off the same platform of evidence, and there is a real need to have that debate locally with individuals. The issue is a population's need.

The report states that we start with a population's need, and we used the five populations as a way to handle that. We have to consider the best way to organise major acute services for that population. We have to take account of clinical evidence, resilience and sustainability and how to maintain the service safely over a protracted period of time. Everyone knows about our experience over the past two to five years, when that was not the case. We have had crisis situations because we could not recruit doctors or depended on locums, so people had to be transferred. It is good to have a local bottom-up approach to planning and agreement.

The clinical forum is not a veto concept. It is difficult to describe it in an organigram, but it is meant to ensure that clinicians have an absolute say in how services are shaped. The outcome will be much more successful if clinicians have that engagement and have their say. My experience during the review was that there was a strong plea to re-engage clinicians in influencing decision-making. It is not about doctors thinking that there is a right way to do things and disagreeing with a community or local organisation; it is about people working together to provide solutions.

On the other hand, we took the view that it was unreasonable for us to say that everything could remain as is. Quite patently, it cannot, so we indicated that in our judgement. However, our judgement was made at one point in time, and that will be tested as we go through the detail.

Our judgement is that Northern Ireland will have about five to seven major acute networks of service. That is quite an important signal to send out about the likely outcome. We are not specific; populations will look at the issue and bring forward responsible solutions.

The Chairperson:

I will let Sam in because he has to leave soon. I ask for questions and answers to be succinct. I will do a Willie Hay: answers need to be a bit shorter.

Mr Gardiner:

I thank the Minister for his presentation. My question is for John. Proposal 62 states:

"Close long stay institutions and complete resettlement by 2015."

How many long-stay institutions do we have in Northern Ireland?

Mr Compton:

I think that there are six at the moment.

Mr Gardiner:

Would all those residents —

Mr Compton:

That is the idea. As members will know, we are already in the middle of the implementation of the Bamford review, and it has that timescale. We are reinforcing the timescale for the closure of those institutions. We are well on the way to doing that. The review suggests a transfer of money from acute services to that area to make sure that the target date is delivered.

Mr Gardiner:

The families have not yet been consulted.

Mr Compton:

No. As you will appreciate, many individuals in that situation have very little family support or

membership. In such cases, there will be advocacy to make sure that nothing untoward is done. Someone will act on behalf of those people.

Mr Gardiner:

Do you have everything that you asked for out of this report?

Mr Compton:

The report is written exactly as the review panel determined. There was no pressure on us to remove anything or not to include something. It is as it is; it is entirely as the review team wanted it.

Mr Gardiner:

Are there things that you would have liked to achieve that you have not achieved as a result of the report?

Mr Compton:

No.

Mr Gardiner:

Are you satisfied with it?

Mr Compton:

I am absolutely satisfied that the review team put together the report as it is written. No one applied editorial sanction to it outside the process. I will be quite straightforward: I assure you that the independent review people would not have tolerated that.

Mr Gardiner:

As the saying goes, we will watch this space.

Mr Poots:

I will clarify. John updated me every two weeks on the report and the emerging issues. During our engagements, I made it absolutely clear that I had asked a panel of experts to give us advice.

I could accept all the report, parts of the report or none of it. However, I asked the panel of experts to draw up advice and pass it on to me. I had to respect the integrity of the people who were asked to do that work. It is not an independent report as such, but it was conducted independently. No political influence was brought to bear, even concerning some of the more difficult issues.

Mr Gardiner:

Thank you.

Mr Brady:

Thanks for the presentation, Minister, and for being here today. At my time of life, I should feel reassured, John, about your plans for care of the elderly. However, I may have to go into more detail.

I am going to be absolutely parochial. Yesterday, Minister, I asked you a question about Daisy Hill Hospital. You talked about a hospital not necessarily being the nearest one but the most appropriate one. I am sure that everyone knows that there has been a lot of speculation since your statement yesterday, and there has also been a lot of what might be considered scaremongering. People want reassurance from you, Minister, John and Andrew that no decisions have been taken.

I spent quite a bit of time reading through the report last night, and I concentrated on the section that deals with acute care. When I read the criteria, and so on, Daisy Hill ticks all the boxes. For instance, when the Committee visited Daisy Hill last week, we saw examples of telemedicine, which you have spoken about quite a lot. It is extremely innovative. There is a facility for GPs to admit patients directly. There is a high-tech state-of-the-art scanner in the new A&E facility and a high-dependency baby unit. There are a number of dedicated and highly qualified staff to whom we had a chance to talk. I think that a new A&E consultant is starting in January. Everything is up and running. It is a cross-border facility: approximately 3,500 people from the South went through the A&E department last year. In total, there were 36,000 patients from the South. At present, six places in the renal unit are set aside for people from north Louth. Daisy Hill seems to tick all the boxes, and there is potential for growth.

I am really asking for a reassurance that no decisions have been taken. As you can imagine, there is a lot of speculation; I know that from talking to people in my constituency last night. Fears were expressed that it is a done deal, and people want reassurance. You talk about resilience, sustainability and patient safety, and Daisy Hill more than qualifies on those issues. A&E waiting times and other indices are good.

Mr Wells:

You have been talking to the 'Newry Reporter'.

Mr Brady:

Not necessarily, Jim. To be perfectly honest, you probably get more coverage in the 'Newry Reporter' than I do. People want reassurance at this point because there is a long way to go, but we do not want initial speculation and scaremongering.

Mr Poots:

I want to do this in a very clear and honest way. I do not want it to be seen as too clever by half.

John will briefly set out the parameters of what is expected of an acute hospital, the necessity for consultants and anaesthetists, and so on. I will then bring a bit of the political angle to it.

Mr Compton:

I will answer your question directly: there is no done deal about any facility in Northern Ireland at this time. The report is explicit in that it did not do that. That was one thing; we had to go back to the Minister to ask him whether he was happy for us to respond in a slightly different way to the original terms of reference, which asked us to comment on each unit. We said that we did not think that that was the right approach. The right approach is to address what should be present in a major acute situation and then talk to local arrangements about how that is applied and how it works, and then come to a proper and responsible solution.

The report also tries to recognise the fact that we can have advice and best practice from everywhere in the world, but it has to fit in Northern Ireland. This is Northern Ireland; it is not

anywhere else. The report acknowledges that. In parts of GB — for example, north-east Scotland, south-west England or central city areas — with populations of 1·8 million people, there will be only four major acute hospitals. We are acutely aware of the fact that Northern Ireland has a different tradition and background, which is why we have come to the arrangement of major acute services on five to seven sites. Local ownership is very important, so there would be local discussions. Health and social care must not detach itself from a population that uses and is very loyal to the service and wants to be interested and engaged in it.

Mr Poots:

The difficulty will be the ability of some facilities to attract anaesthetists, consultants, and so forth. That will be a challenge. In fairness to Daisy Hill, the chief executive of the Southern Health and Social Care Trust is keen for the hospital to be sustained in its current form, which is a good starting point. In a bigger future model, the hospital, as it currently exists, would not be sustainable, so it will need to be expanded or the service will contract from it. I have made that very clear pitch. Anyone can see where the trajectory lies. More people must be drawn into Daisy Hill. Northern Ireland does not have the numbers, so it is a matter of people from north Louth and Monaghan using the service. That is absolutely reasonable.

The Chairperson:

That has been happening for years.

However, back to my question: NIMDTA has to sign off on local plans, which affects recruitment and other issues. If a local solution is devised, checks and balances should be built into it to ensure that it does not proceed if that is the will of the people making those decisions.

Mr Poots:

There are no immediate pressures. Time is on our side to get the solution that people are looking for, which is to ensure that facilities do not simply stay the same but are enhanced. There is a lot of time to work up a solution.

The Chairperson:

So there will be a commitment to recruitment across the board. It will not be a case of Belfast getting the first pick, with the remainder getting what is left.

Mr Poots:

Let us put it like this: 2,200 babies are currently delivered in Daisy Hill. We could not ask another hospital to do that without giving it a significant capital injection.

The Chairperson:

There are other elements to that issue.

Mr Poots:

There is a series of issues. There is no immediate threat to Daisy Hill Hospital for a whole raft of reasons. There is an opportunity to ensure that more people use Daisy Hill Hospital, which will help to ensure that it maintains its current services.

The Chairperson:

I will try to keep this session as tight as I can. Mickey, I know that you wanted to ask about the Commissioner for Older People, and I will bring you back at the end if there is time.

Ms Lewis:

I thank the Minister and the panel for giving their time to come here today. I welcome the report. I do not think that there is anyone who does not agree that major changes are needed in the health system. How will you bring GPs together into 17 groups? How will you liaise with the British Medical Association (BMA) and the Royal College of General Practitioners?

Mr Compton:

A lot of work is already under way, and the Committee had an evidence session recently about primary care partnerships. What we refer to as integrated care partnerships is the same thing, but it allows other disciplines to be involved. We have 17 such arrangements in the Province. Interestingly, just to reflect on the local debate, there has been no one size fits all. We have asked locally about the best way to do it. For example, in the west, it was thought that it could be done best with two groupings, whereas Belfast wanted four groupings. We did not have particular problems with that. It was built up locally and is about local ownership of a solution.

In my discussions with all the GP representatives, I have had nothing but very strong support for the model. Clearly, they are concerned about the ability to discharge their duties and that the financial modelling, which will see a transfer of £21 million over time into family practitioner services in primary care, is designed to provide that reassurance. I have heard nothing from any member of the GP fraternity that is other than supportive for our direction.

Mr McCarthy:

Thank you for the report. There are some good things, and there are also some not so good things that could be very worrying. I will follow on from Pam's comments. Will rural GPs be expected to close their practices and join with a larger practice, which would mean that patients would have to travel further?

Mr Compton:

No, not at all. The model is about GPs working together as networks. It does not mean that GPs have to change their buildings. If GPs decided that it was right to change a building for a better outcome, that would be a matter for debate and discussion. However, there is no plan to dismantle what people recognise as the 350-plus general practitioner surgeries. We are talking about those GPs working in a different way so that they have more evidence and can look at the way in which they are treating illnesses, such as long-term conditions, in the most responsive way and with the minimum variation in treatment, which will lead to better outcomes for individuals.

Mr McCarthy:

You mentioned your review of respite care. What are the pathways and structures for the development of respite services? Will it be statutory or private, and will users be asked for their input?

Mr Compton:

When we spoke to people, we were told very firmly about the need for respite care. Of course, there is a spectrum of respite care. The care can range from one or two hours to allow people to leave their home to do something to a week-long break. Respite care cannot be designed to a one-size-fits-all arrangement. However, it will clearly have to be a local decision involving families and carers. The inclusion of carers in the review, and making a strong statement about

them, recognises their central importance.

Mr McCarthy:

Proposal 46 is about the development of a new Headstart. Is that a replacement for Home-Start, which does an excellent job? We are always asking for it to continue.

Mr Compton:

No. We have a lot of things called Sure Start and Home-Start, and a lot of local projects grouped together. The objective is to get that into one coherent strategy so that everybody is pointing in the one direction. The idea is that, from pregnancy to the age of five, we put a huge effort into making sure that youngsters are developed in such a way that they can benefit from the education system and that early problems and difficulties are quickly diagnosed and sorted out. There is very clear evidence that, if that is done by the age of five, the use of services in later years is reduced. It is not so much about reducing services but about producing healthier kids with better social well-being.

Mr McCarthy:

I agree 100% with that, but there is a fear that people using Home-Start are losing out and that it will have to close. Can you guarantee the Committee that that will not happen and that they will be brought in immediately?

Mr Compton:

We can look at the £83 million transfer of funding that we mentioned. From memory, £41 million will go into community services. Child health and family and childcare are part of community services. We want to put transitional money into that in the first instance, and subsequently money will come out of the system as the system starts to change.

Past reviews were criticised because they told people about changes but not the other side of changes. In this review, we specifically wanted to say: here are the changes, here is the other side of the changes, and here is what will happen as a consequence of the changes.

The Chairperson:

I do not know whether you have seen 'The Connected Baby' by Dr Suzanne Zeedyk. You need to watch that DVD and speak to her if you are developing services for children between nought and five.

Kieran, how long is that list? I might let you back in at the end as well.

Mr McCarthy:

I want to carry on from Sam's question about the residential homes that you want to close. We have been given a commitment on several occasions in this room that a number of special patients in Muckamore will be given a guarantee that they can remain there for as long as they live, because that is what they and their relatives want. I am talking about a very small number of patients. Can you give us that commitment again today?

Mr Compton:

As with all issues in which we are handling very difficult individual sets of circumstances in long-stay institutions or residential care, solutions have to be tailored for individuals and individual groups. There will always be the ability to tailor those individual solutions. The review is not about running around wholesale getting people to pack their bags and move. It is about a sensible direction over a period of time. If there are particular issues with which we have to deal, of course they will be dealt with in their individual circumstances.

Mr McCarthy:

That is reassuring for that small number of people.

Mr Poots:

There will always be trauma in moving people from long-term institutions. However, I can assure you that there are still many people in Muckamore who should not be there. There are better care models for those people.

I want to touch on the issue of children, which currently crosses a number of Departments. I think that we can do much better than we do at present. Whether one Department takes on more

responsibilities for children or we have a better integrated way to bring Departments together to work more closely on delivery, we can do more, and we can do better. If we have early interventions, I am confident that we will deliver far better outcomes for young families, particularly vulnerable families.

The Chairperson:

If we get it right initially for our most vulnerable people, there will be less pressure on the Department of Education, the Department for Employment and Learning, the Department for Social Development and the justice system.

Mr Poots:

The Department of Culture, Arts and Leisure (DCAL) and the Office of the First Minister and deputy First Minister (OFMDFM) also have roles to play.

The Chairperson:

Kieran, if you need any more information, I will let you in again at the end. I will take questions from Jim, John, Gordon, Paula, Mark and Mickey. Jim, you are next.

Mr Wells:

Sounds like a '60s pop group.

You had an excellent interview this morning, John, on 'The Stephen Nolan Show'. In fact, I felt sorry for him at the end — I did not think that I would ever have to say that. You explained very well many of the points that I would have raised this afternoon, and I will listen to the interview again on iPlayer to go over your points.

I have a couple of questions. You said that, if hospitals can prove themselves to be safe, resilient and sustainable, they pass the test to continue with their present range of services. I am absolutely certain that the chief executives of the health and social care trusts are, from yesterday, starting out on a programme to prove that all their hospitals are safe, resilient and sustainable. What happens if they all deliver the goods and all come up with a programme that indicates that they satisfy those tests? How do you then reach your target of five to seven hospitals with A&E departments?

Mr Compton:

Since it has not been possible to produce safe, sustainable hospitals in the current model of 10, I would be very surprised if people were able to create an environment in which the difficulties that we have today were overcome. If the difficulties that we have today in many of our facilities were as easily overcome as that, I would expect solutions to have been found some time ago.

It is quite clear that we have difficulties — with the volume of activity in some hospitals and its effect on quality of outcomes, in sustaining medical cover and medical staff and in working with regulatory bodies such as the Northern Ireland Medical and Dental Training Agency (NIMDTA). By the way, NIMDTA is not being given a veto. The review is quite clear that NIMDTA should be much more integrated in how it works in the hospital sector and should not sit outside the sector creating difficulties.

Given all those issues, I would be very surprised if we could sort that out. Take, for example, the management of coronary care and cardiac catheterisation in particular: I cannot see how we could have 10 24/7 cardiac catheter labs running across Northern Ireland. People are much more likely to have a better outcome and survive longer if they go through cardiac catheterisation. It is simply not organisable in that way.

Mr Wells:

The chief executive of the Southern Trust is already committed to both her hospitals reaching those standards. What happens if they enter negotiations and track a large number of patients from the Republic to give you the quantum that you need to sustain all those services in Daisy Hill? Is that an important aspect that could lead to more hospitals being retained.

Mr Compton:

Of course that is an important aspect, which is why the review team went to Dublin on a couple of occasions to talk to colleagues in the Southern jurisdiction. The words at the bottom of page 108 of the report were formally agreed with the Southern jurisdiction; they are not accidental words written by the review team. We were very clear that we wanted those words to be precise and understood. My understanding is that, at ministerial level, those words are fairly understood

and agreed.

It is common sense for both jurisdictions to talk to each other. It is nothing to do with politics; it is to do with common sense. If we can assist colleagues in the south Down area through to the Cooley peninsula, which will bring more activity to the Newry area and to the hospital, there will be a better outcome for patients. It is the same for the south-west hospital, which clearly indicated that it wants different arrangements, and for Derry, which indicated that it wants different arrangements for cancer services. That makes absolute common sense for patients and for better outcomes. We have no difficulty whatsoever with that. The reason why we spent so much time on that area was to achieve a practical outworking for both jurisdictions.

Mr Poots:

Coming further inland, Craigavon Area Hospital has a cath lab that does not operate 24/7. We could provide cath lab facilities for people who live well into the South. Even for people who live a couple of hours away, it would be a reasonable service to supply and would enable Craigavon to move up to a 24/7 system, which would greatly enhance the services to the west of the Province.

Mr Wells:

I have one small technical point. For some reason, your interviewer on radio this morning got very touchy when you talked about obesity; I cannot understand why. The report mentions some form of fat tax.

Mr Compton:

That is how it was portrayed; that term is not in the report.

Mr Wells:

I understand that you are trying to discourage people eating unhealthy foods, which is a good idea. Can we do that legally?

Mr Compton:

That is, again, why the wording in the report is very careful; we know that this is between a

devolved and a national issue, so there is no word of a tax or anything like that. The report asks for an exploration about pricing, which is reasonable. That was asked for because we know that there is a direct correlation between pricing and consumption. From our point of view as a review team, given that we know that there is evidence on the correlation between pricing and consumption, it does not seem unreasonable to ask colleagues and those in the Assembly who are working on the issue to reflect on that.

The Chairperson:

Jim is asking on behalf of he who shall not named: "KFC: yes or no?" That was what was asked on the radio this morning.

Mr Poots:

If there is a tax on crisps, I am going to make a plea of mitigation for Tayto cheese and onion not to be included. *[Laughter.]*

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):

The Executive have discretion to introduce taxes that are not the same as national taxes. We cannot change VAT or income tax, but there is some scope for novel taxation powers.

Mr McCallister:

The national Government have been toying with the idea of a plastic bags tax. Do you think that the discussions with the local public about A&Es such as those at Daisy Hill or the Causeway Hospital developing into other models of care? Is that where the issue is likely to go? Jim and I are South Down representatives. That is a neighbouring constituency of Newry and Armagh, where Daisy Hill is located. It is my nearest hospital. How do you bring people in, engage with them and have that debate? Making changes such as that is a very emotive subject.

Mr Compton:

We went into some detail about the definition of emergencies, from regional trauma, which people understand, to blue-light trauma, which people also understand — it is a state of collapse or something like that — to urgent care and minor injuries. Any population needs access to all those services. The difficulty is that we have a one-size-fits-all service. People go to one area to

get all those things done at one point in time. That causes some of the difficulties with seeing people quickly and properly. We need to look at the component parts of emergency services. We indicate in the report that, if you use what is known as the Manchester triage system, which is a straightforward gradation of people turning up, about 50% of people who come in would not qualify as emergency cases.

It is important not to turn people away. They should be given information so that they can go to the correct place, and we must ensure that an alternative is in place. That is why the review is joined up and includes integrated care partnerships, greater involvement of out-of-hours and general practice, and federations of GPs working together. There are things that people should go there for and get sorted out. Sometimes, people do not go because they feel frustrated that they are unable to get the service that they require. The review tries to join that up. It should not be read as talking about a single A&E; it is about trying to join up all of that.

Mr McCallister:

There are some very laudable targets, such as increasing the number of consultants and increasing throughput and access to all our health services. Will that not be tremendously difficult if £83 million is taken from the acute side to put into the community side over a five-year period?

Mr Compton:

Any change, of course, is a challenge. The difficulty is that, in many instances, we probably overuse our hospitals for the wrong things. It is about getting the proper alternative to such overuse to allow money to be taken from hospitals. It is not about denying someone who needs hospital admission or access to treatments or services. Many people with long-term conditions frequently find themselves in hospitals. Perhaps they will have multiple admissions in a year. If community services were better organised, the number of times that they may have to go to hospital could be restricted. That is not because you want to restrict hospital admission, but because people would not need it, and their outcomes would be better. If that were to be the case, the ability and need for hospital work is reduced. Hospital work would concentrate on what it wants to do, which is to deal with the people who are most ill and most in need of support and treatment in the correct environment.

Mr McCallister:

The Minister made a point about working better together with Departments. I do not think that there will be any argument against that. In fact, we are very supportive of that. It is right that you want to move as many people as possible out of institutions such as Muckamore, but the difficulty is that we do not have the right support mechanisms. Supported living could be used for some conditions, but there is a dependence on other Departments doing their bit first. It is about how that is made to work.

The same applies to the Headstart strategy. I very much welcome it, but we have different strategies, and we need to tie them all together. Yesterday, in answer to a question on your statement, you quite rightly talked about that. As well as you as a Minister, others have a responsibility for health. The Chair mentioned the Suzanne Zeedyk DVD, and you are tying in issues such as that. OFMDFM has a childcare strategy, and the Department of Education has a nought-to-six strategy. How are we tying all those bits of policy together? Do you see this as the overarching strategy? Which Department will take responsibility to get the outcomes that you and the Chair mentioned? Will it be the Department of Education, the Department for Employment and Learning or the Department of Justice? If we get it right, we could make a huge impact, but someone has to take the lead and get other Departments involved.

Mr Poots:

Over the past six months, there has been engagement, which I hope will rise in significance. We spend a reasonable amount of money on it, and we could get better value and deliver better outcomes by working more closely together. I have not detected any reluctance on the part of other Ministers. I do not think that Andrew has detected any reluctance on the part of other senior civil servants. It is a matter of how we approach the issue, put our heads together, remove the unnecessary silo walls and work as one Government for the people of Northern Ireland to ensure that we deliver a better service. We recognise the fact that more can be done; let us get our heads around how we do it.

The Chairperson:

With the Department of Health taking the lead.

Mr Poots:

I do not want to say that, because the Department of Education may think that it should take the lead. I am not sure that it does, but we need to engage in a positive way. The Health Department is not looking to grab it all: it has a fair bit to do, and it will do it if other Departments wish it to. This is not a grab to bring more powers into the Health Department.

The Chairperson:

I do not think that anyone is suggesting that you would do that. We had a similar conversation this morning at a Committee for Employment and Learning meeting about people not in education, employment and training (NEETs). We agreed that it is a cross-departmental issue, but, very clearly, the Department for Employment and Learning is in the lead, needs to give leadership and drive the issue from within the Department. We do not suggest that you are grabbing powers, Minister.

Mr Poots:

I would be happy to do it, but on the basis of agreement with our other colleagues. Let us just see exactly where they are on it.

Mr McCallister:

Like the Chair, I am nervous that no Department is leading on the issue. It is always someone else's job. I want someone to lead on it.

Mr Dunne:

I thank the Minister and the panel for coming before us. Is it fair to say that all the consultation before the publication of the report has somewhat reduced its impact? How do you intend to continue that consultation?

My second point — it has been raised previously — concerns staff. Staff are our most valuable resource, and the report has raised concerns among staff throughout the health sector. We need staff co-operation to implement the report's proposals. How will you engage further with staff to reassure them that the report represents the best way forward? We are all concerned about the morale of front-line staff. A proportion of staff feels undervalued, and many feel that

they are working under excessive stress. Those issues need to be considered, and I trust that you will look at them in more detail.

A further concern is the future of the Belfast hospitals, which has been mentioned. As I understand it, the proposal is to move towards one hospital. The Royal Victoria, the Mater and Belfast City hospitals will all effectively become one hospital — one hospital authority is, I suppose, the proper term. Will that result in a reduction in A&E services or a major review of provision in Belfast?

Mr Poots:

I can deal with that. This morning, I engaged with and offered to do workshops with the BMA, and to sit down with GPs, one to one in as many circumstances as possible, during such workshops. I am engaging with the Royal College of Nursing tomorrow. That engagement work will continue. As I said, we would like to bring a debate to the Floor of the House so that the public debate does not go away and the public remain engaged. It is very important that we seek to draw down the public's views. Perhaps we will not always agree with the public's suggestions. We have to demonstrate leadership and show that, clinically, we can get much better outcomes and that this is the right mode of direction. Sometimes, there will be loud voices, but those voices may not be speaking facts. There is work to be done, but we need to engage strongly with the public and hear what they have to say. We intend to continue to do that.

During the review process, John has always said there was £4·3 billion in the budget at the start, and that at the conclusion there was £4·6 billion in the budget. We are not looking at wholesale cuts in staff. A reorganisation will take place. As a consequence of the funding, there will be some reduction in staff, but it will not be massive. We have avoided compulsory redundancies at this point.

Let us look at issues such as residential homes. What are we doing with residential homes? We are not throwing people out of those homes. At this point, we are identifying that, given the number of people whom we anticipate coming into residential homes, we will need considerably fewer. Where they are in place, they will probably be more for respite care than anything else. So what happens to the staff who work in residential homes? The reason we require fewer

residential homes is that we will have more packages for people in their own homes. The people who provide care in residential homes can easily transfer to providing care in people's own homes in the domiciliary sector. That will not be hugely painful, but it will be a change for those types of workers.

There will be other changes. Some services will become more specialised at fewer sites, and so forth, but it is more about reconfiguration than redundancy.

Dr McCormick:

I want to come in on Belfast A&E departments and consultation. The follow-up to the report is the development of detailed specific plans for different issues. Where there is a need for a significant change, the standard process of formal public consultation will be required. As you point out, one example that is actually ahead of the review process is what happens with A&E configuration in Belfast. A temporary change has been made. The fact that a temporary change was needed means that there is a need to consider what the best permanent solution would be. I had a meeting with representatives of the Belfast Health and Social Care Trust this morning, and work is in hand to develop proposals for public consultation in the new year about how that is settled on a permanent basis. That will take its course within the principles set out in the report, but, case by case, as those arise, there will be proper processes of engagement and follow-up public consultation.

Mr Poots:

In August, September and October of this year, 12-hour waits for A&E services in the three Belfast hospitals ranged from 63 in one month to 89 in another month. In November, at the two-hospital site, the total was three. That is a demonstration. Doctors tell us that they are being spread too thinly, their skills and services are being compromised, and junior doctors are being left to make significant decisions and are finding it difficult to come to those decisions. Where registrars and consultants are in place, there will be better outcomes and decision-making. There were considerably better outcomes in November than in the previous three months. People need to reflect on that and consider why it is the case.

The Chairperson:

There have not been very many 12-hour waits in the Southern Trust area over the past years. I ask that you bear that in mind.

Ms P Bradley:

I would be lying if I said that I had read the report from cover to cover, but I have read the highlights. I agree with the majority of what I have read. I think that if you took this document to many health professionals they would say that it states what they have been saying for years; that we should be doing X, Y or Z. When implemented, it will make such a difference, especially to social care. I am very happy to see such an emphasis on social care, as I have said time and time again that it is the cornerstone.

The first of my two questions is slightly parochial and, in that sense, is a bit like Mickey's question. North Belfast is serviced by the Belfast Trust and the Northern Trust. There is the Mater Hospital, which is a blue-light facility, and Whiteabbey Hospital, which is not, because it was taken off us under the previous Administration. Have you any plans for the Belfast area, and will you clarify the difference between acute hospital networks rather than acute hospitals;

The other point that I want to bring up is technology in hospitals. In the hospital where I worked, we had to log on to three separate computer systems just to complete a front-sheet referral form, which is one sheet of information. Also, at the end of the patient discharge process, information had to be input into three computer systems. Staff are extremely busy with having so much to do, and yet they are expected to use that many systems.

Also, in my area, with there being two separate trusts, someone taken in a blue-light vehicle to the Mater Hospital for surgery might, a couple of months later, be transported in another blue-light vehicle to Antrim Area Hospital for more surgery, intensive care, or whatever. Again, that means two different computer systems with two totally separate sets of notes. That often means that a surgeon in one hospital cannot get the notes from another hospital. I have heard of families getting in their cars and driving at speed to pick up notes from another hospital.

The current technology is not workable. In no way does it benefit the patient, and it costs a

great deal of money to maintain the computer systems that I mentioned, and there are many more besides: for GPs, hospital medics, pharmacies, and so on. Not only would streamlining make major efficiencies, it might go a long way to reducing stays in hospital and, ultimately, the number of patient deaths.

Mr Compton:

I will pick up on two points, the first of which was the argument about whether adjacent populations should talk to each other about how they organise services. The answer is yes, they should, and the report is quite clear about that. Although we expect population planning to take on the core activity for that population, those populations are, no matter how you draw them, somewhat artificial. There needs to be a concept and a discussion with the adjacent population. So we expect that, when the local commissioning plans for the Belfast and Northern Trust areas come back, there will be interplay on the boundary issues, just as we might expect between the Northern and Western Trust areas, the Southern and Western Trust areas, or wherever. It is just common sense for that to take place.

Part of this is about becoming a bit more efficient. There is a lot in the document about technology. At public meetings that I went to, I heard profound concerns about the backwardness of our technology when people compared their experience of the health system with the rest of their lives. One of the key issues for us is to sort out the technology.

In the document, we highlight some of the issues that we think are quite important, starting with having a forum in which we can talk to the industry so that we understand what is happening there and they understand what our needs are. Then, at a certain point, we will be talking a similar language before getting into procurement. We are looking at having a single system and at better data warehousing of information that can be properly accessed in a way that does not breach an individual's confidentiality but enhances his or her outcome because the information is available. That concept percolates all the way through the report. If we want to have a modern, effective health system, underpinning that will have to be a much more modern and effective technological system.

Dr McCormick:

Page 120 of the report specifically mentions the electronic care records. Those are being piloted and are ready to roll out in order to deal with exactly your point about the commonality of information and making the same information available to clinicians wherever they are.

Mr Durkan:

I apologise for being late. You might think that a pattern was beginning to emerge, given that I was late for the Minister's statement yesterday.

The Chairperson:

I was sympathetic, because the wrong information on the annunciator caused some confusion yesterday. Really and truly, for that reason, Members who were late should not have been left to the end of questions to the Minister.

Mr Poots:

We were very sympathetic, too.

Mr Durkan:

Being left to the end meant that we knew what questions the Minister did not want to be asked because they had not already been put to him.

I very much welcome the report and congratulate John and his team on its compilation and publication. It is styled as a road map for the future, but I see it more as a compass. It points us in the right direction without necessarily giving us the specifics of how we will get there. I certainly like the destination, and the report crystallises a lot of the ideas, which have been espoused by this Committee and by Health Committees long before I came to the Assembly, on a shift of focus from secondary and clinical care to primary and social care.

Other members mentioned the report's greater emphasis on preventative measures and its nod to cross-border co-operation. I have always been a big fan of integrated care partnerships, and I am glad that the need for transitional funding for that is identified and, indeed, costed. I also raised that issue previously. It is vital that no vacuums in care are created as we move from one model to another. Are you confident that the funding is forthcoming and that it will be enough?

The lack of specifics in the report causes the public concern. Reference is made to an expanded role for community pharmacy in delivering the new model. People in that service will be curious about whether that will involve enhanced funding to enable them to play the role envisaged for them in that delivery. The report is not specific in identifying where and when the reduction of acute services will take place. I appreciate that a lot more work is to be done on that.

Gordon raised the vital matter of staff, and I was able to ask the Minister a question on that yesterday. I appreciated the Minister's answer yesterday that the report is about the health service rather than health servants. However, it is important to note the importance of the morale of health servants, because, without happy health servants, there will be no health service.

Minister, you referred to the budget moving from £4·3 billion to £4·6 billion. In real terms, given the ageing population and increase in demand, is that an enhancement —

Mr Poots:

That is why the report was necessary.

Mr Durkan:

— or a reduction? What will be the next steps in the process? I mentioned the staff, and I appreciate that you spoke to the BMA this morning. In an earlier evidence session, I emphasised the importance of including the unions in the consultation period. That should be done as a matter of urgency.

Mr Poots:

I will deal with the finance and pass the other issues on to John. We started off with a budget of £4·3 billion. That is moving to £4·6 billion, which is an increase of 8%. That would probably not keep up with inflation over the period, although there has, for a couple of years, been a freeze in the pay of staff earning over £21,000, which helps. However, our problem is that, if we were to carry on doing things the same way as we do currently, we would, ultimately, have to cut services. The costs associated with demand are rising by about 4% each year. That is largely to do with the population getting older.

The budget increase is 8%, but if you consider that our costs are rising by 16% and then add on the cost of inflation, you can see that there is a pinch point, which can be met only by extending waiting times for services. That is why, at an early point, we identified that we needed radically to reform how we provide care. I asked the panel to take on the report on the basis of delivering better outcomes. The members of the panel were aware that this was the budgetary envelope that we had to live within. In spite of not getting the rise that we would like to get — I appreciate that other Departments in Northern Ireland suffered far more than mine in the Budget rounds and have a great degree of sympathy with a lot of my ministerial colleagues — we believe that we can get better outcomes from the budget that we have if we use that money more wisely and spend it better. That is how we ended up with 'Transforming Your Care', and John will explain how it will work.

Mr Compton:

On the issue of morale, it is worth observing that we met many, many, many staff who work in the system, not one of whom wanted that system to remain in its current form. They clearly knew that something had to give. That is why we said early in the review that we were failing staff by not making reforms. One of the compelling arguments for change is that asking staff to work in the current pattern and manner is failing them, and they know that. There is an appetite and enthusiasm for making the change.

As for whether the shift of £83 million and transitional funding of £70 million are enough, no restriction was placed on what the review panel could or could not do. When we looked at this, we had to do so with a degree of realism, a degree of achievability and a degree of deliverability, and we felt that the numbers specified in the review were just that: realistic and deliverable. If we go ahead on the basis of those figures, some of the shifts into areas such as family practitioner services and community care will be quite significant in proportion to what is currently spent. The shift into community care, for example, lifts its funding up by around 9%. Those are quite large numbers, so there is a real opportunity for something different.

There will always be a debate about whether there is enough money. I will finish talking about the money issue by saying what I said at the public meetings: we are in a much better place to talk about what should or should not be invested in health and to provide advice if the model

that we have is the right shape and structure. It is very difficult when people just turn round to you and say, "Put your own house in order first." This is, if you like, putting the house in order and giving you a more coherent argument. The panel was not constrained, and we said what we said.

Mr Durkan:

Thank you, John. I acknowledge your recognition of the importance of staff during the consultation phase, but they have been in a state of perpetual change for so long. That is why it is so important that we get this right and arrive at the destination without running out of petrol on the way.

Mr Poots:

I believe that we have enough money in the system to deal with people's needs but not enough to deal with people's abuse of it. For example, four times more people in Northern Ireland have consultations in GP surgeries than in the Republic of Ireland. Our figure for that is also 25% higher than in other parts of the UK. We have more people coming to A&E units than should be the case. Work in Craigavon identified that at least one third of the cases coming through the doors of A&E should not have been doing so. Some 25% of people who call ambulances should not do so. Then, we have others who think that they can eat, drink or smoke themselves into bad health and that the health service is some garage repair shop that will put them right. Very often, it is impossible to put them right.

The public health agenda is critical. Around Europe, the spend on public health is around 3%; we spend less. It is important that we get the message out to people that they are responsible in the first instance for their own health and that we are there to meet their needs when something goes wrong. Far too many people engage in activities that lead to their coming to hospital absolutely unnecessarily.

The Chairperson:

Minister, I know that we are tight for time, but I will let Mickey in, as I promised, and then Kieran will ask one question only.

Mr Brady:

Maybe we should all follow Jim's lead and become vegetarians.

Mr Wells:

Hear, hear.

Mr Poots:

His waistline is too large. *[Laughter.]* He does not meet our requirements.

Mr Brady:

You talked about a holistic and consistent approach to the assessment of older people's needs and an equitable range of services. We have the advent of a Commissioner for Older People, Claire Keatinge. That position seems like a logical conduit for the groups or voluntary organisations such as Age NI and the Age Sector Platform that deal with older people, or "senior citizens", as Sam would have them termed. Rather than the commissioner being on the outside, will she become an integral part of that kind of project?

Mr Compton:

The answer to that is yes, because it would not work otherwise.

Mr McCarthy:

John, you talked about meeting a lot of staff on your rounds before you produced the report. As I understand it, the shared services document was not out and about at that time. I do not know about other members, but I am hearing concerns from many constituents about what is contained in that document. In other words, people who live in Newtownards are concerned about having to travel to Omagh or Derry. Have you an answer to that?

Mr Poots:

Through shared services, 500 jobs will become 400. Quite a number of people who currently work in personnel, for example, will find that their job moving perhaps 60 or 70 miles away. However, training will be offered to enable those individuals to go to a closer shared services office. For example, people in Newry who previously specialised in finance would not be

expected to travel to Ballymena, because jobs would be available in Armagh for those individuals if they retrained in personnel. There will be opportunities for retraining, and there will also be opportunities for the trusts to absorb a number of those staff. It will not lead to wholesale compulsory redundancies. I cannot rule out there being some, but there will be very few. When it comes to elections and talking about health, all of you say that we need to cut management and administration, so do not complain when it happens.

Mr McCarthy:

I thought that no jobs would be lost, but if that is the case, jobs will be lost. You are contradicting yourself at the final hurdle. John, you said this morning on 'The Stephen Nolan Show' that no jobs would be lost.

The Chairperson:

I am glad that you asked that question, Kieran. There is a big shift away from the west as well. We talked about it last week and are very concerned, but that is not for today.

Mr Poots:

We have put something into Omagh, whereas others took services away.

Mr Dunne:

Is there not a new hospital being built in Enniskillen?

The Chairperson:

There is, yes.

Minister, quite a few times, you mentioned people smoking, drinking and eating themselves into ill health or to death. We could be forgiven for thinking that you might be having a pop at people in socially deprived areas. I remember what you said in the House about the upper Finaghy bus route. The fact is that a lot of people who are professional or consider themselves to be middle class suffer from high blood pressure and stress. Ill health is not just caused by the lifestyle choices of the poor and not so famous; we all have medical conditions as a result of how we live. There are times when all of the focus and attention is on people from socially deprived areas, and that is not fair. You might want to bear that in mind.

You talked about cardiac catheterisation. We have seen services being reconfigured. I know that some people go to the minor injuries unit when they should go down the road to the A&E unit in Craigavon. I do not know whether anybody who goes to A&E in Craigavon is told that they can either sit there for five hours or travel half an hour down the road to Dungannon and be seen in the minor injuries unit. I do not know whether that is said at the point of triage in Craigavon, but it would certainly make sense.

There has been quite a focus on Daisy Hill Hospital. In defence of the Northern Trust and the Causeway Hospital, services like cardiac catheterisation could remain. I hope that this is not an all-or-nothing scenario and that you can work with local trusts and local commissioning groups to decide what is needed. I am conscious of the geography surrounding the Causeway Hospital and the radius from which people look to it for services such as cardiac catheterisation. The fact is that people are a long way away from the next hospital that offers such services. What happens when someone in Draperstown, for example, needs a cardiac ambulance? Is there a plan to retain services where their provision is of high quality? Is there any attempt to dilute this reconfiguration?

Mr Compton:

I will give you a specific example: look at the work undertaken recently in urology. We now have three centres: Craigavon, Derry and Belfast. That was agreed across the whole of Northern Ireland. Those three inpatient centres support the rest of the hospital network through day cases and outpatient services, and they provide assessments for patients who may have presented with a problem that turned out to be urological. That is the model and the way forward. It responds to the accessibility issue.

The review was very mindful of having to design some direction of travel and a road map that accommodates and fits Northern Ireland. I think that we have done that. That was a very clear objective at the outset, and we made that quite explicit, almost on the front page of the report. In the end, that model has to have legs and be believed in, in Northern Ireland. You cannot just apply something from somewhere else.

There is an important issue of volume in some situations, and there is interplay between the

volume of activity and time. All of that will be taken into account in the organisation of the major acute networks across the Province. Clearly, those must be important criteria. Perhaps behind your question is another: is this a recipe to locate everything in Belfast and take away everything outside Belfast? The answer is that it absolutely is not.

The Chairperson:

We accept, for example, that one regional trauma unit is probably a practical solution, but the fear is that some people will, if you like, drop off the edge because they are too far away. Correct me if I am wrong, but I understand that the report acknowledges that some services are too far away for those people, but that that is just tough.

Mr Compton:

Look at the published evidence on the travel time and the outcome — and the outcome is the important issue. What is the best outcome for someone? A lot of work on trauma, for example, has been carried out in Scotland. It shows definitively that travel time is less important — it is not unimportant but less important — than getting to the right place and the right unit that can fix you. What gets you the best outcome is getting to the right place and the right person in the right time. That is one of the principles that governed what we have to say.

Most people will ask, "Why would you drive past that unit to go somewhere else? Surely it would be better to go there. They will do something and then take you somewhere else." In fact, that is often the wrong thing to do.

The Chairperson:

No one on the Committee has said that. In fairness to all members, none say that people should go to the wrong place. We know that going 10 miles down the road can give people a better outcome. We do not disagree with that, John. However, it is important to recognise that travel times make an impact. You have seen the survey that was done in Scotland. Are the people who die on the road, having been worked on in the back of the ambulance and made it halfway down the M1, included in the statistics?

Mr Compton:

Obviously, we will get you all that information if it is helpful. The point that I want to make is that the reason that we came up with the five to seven networks is, in part, to understand accessibility in Northern Ireland and travel times for major and critical issues. It is not just applied as some sort of arithmetic formula, such as 1·8 million people divided by a population by 450,000 equals 4 acute hospitals. That is what would happen in lots of other places. The report takes account of some of the infrastructure and journey-time difficulties in Northern Ireland. That is why the report is explicit about the hospital in the south-west. It is a very direct response to the issue of Northern Ireland. That is a real issue; that is why there is a hospital in the south-west. There is recognition of the rurality and accessibility issues of Northern Ireland and of the road infrastructures. The review has been quite clear about that. I hope that, in the outworkings of the review, people will see that as a fair, balanced and proportionate response.

The Chairperson:

I am conscious that we are a few minutes over time. I thank Andrew, Edwin and John for coming today. It would be helpful to have an update on progress. Will you come back towards the end of January? I agree with Mark that the report lacks specifics. We might be able to dig further into those specifics in the new year. John, you did not answer the question about who is on the forum, and we will need more specific information on that.

I would also like a flavour of the kind of responses that you are getting. I know that there is no formal consultation as such, but, presumably, people will be engaging with you and making their thoughts known. We would appreciate that information as well. We would be especially keen to hear how the trade unions feel about it. A dedicated meeting on that towards the end of January would be helpful.

Mr Poots:

We are always in the hands of the Committee. I draw one small matter to your attention. On 23 November, John Compton and Deirdre Heenan attended the Committee. I noted, in Hansard, that Deirdre Heenan referred to a number of areas in south Down that are about 17 miles from the out-of-hours doctors. The Hansard report incorrectly recorded Ballymoney as one of those areas. I

am very disappointed Committee members from that area had not read Hansard and had it corrected it to read Ballyroney. Of course, we are always looking at boundary reviews, and if it wants to go into the Lagan Valley constituency and be properly cared for, we would be very happy to do that.

The Chairperson:

That is very helpful. We wish you all a very happy Christmas, and we will see you in the new year.