Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Transforming Your Care: Ministerial Briefing

20 March 2013

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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

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 Board

The Chairperson: You are very welcome to the Committee, gentlemen. The meeting is quite timely on the back of the statement that was made in the Chamber yesterday. Although we had an opportunity to ask questions, today is the opportunity for people to do so in more detail. Minister, I will hand straight over to you for your presentation, and then we will open the meeting up for questions.

Mr Poots (The Minister of Health, Social Services and Public Safety): Thank you. It is not my intention to repeat a lot of what was said yesterday. I do not see the point, so I refer any of you to the statement that was made yesterday. There are a couple of things to add.

We could perhaps have covered the review of paediatric cardiac surgery a bit more. I recently approved the paediatric congenital cardiac services (PCCS) post-consultation document, which was submitted to me by the Health and Social Care Board (HSCB). That document proposed eight options for the future commissioning of the PCCS for Northern Ireland, and unlike the majority of other consultations, the HSCB was not consulting on a preferred option. Rather, the focus was on the development of an appropriate framework, which will be used to inform the future model of care for children in Northern Ireland with heart disease. The post-consultation document that I have approved makes it clear that, although standards proposed in the service specification draw on safe and sustainable process, they have been amended to reflect the specific needs of the Northern Ireland population.

I have asked the board to facilitate the PCCS working group to identify a preferred way forward and, subject to approval by the board, to submit that to me for consideration as soon as possible. Following consideration of the board's recommendation, I aim to announce my decision on the preferred way forward in the months ahead. I am advised that the HSCB continues to ensure that robust arrangements are in place for all children who require that service as things stand.

I should add that I believe that an e-mail was supposed to have been sent to you on the issue, but, for whatever reason, you have not received it. I apologised yesterday in the House for that, so it is on the record. We did not mean to snub the Committee. I reiterate that today.

There are a couple of other things that perhaps we did not cover fully yesterday that might be useful to us. The turnaround and support team (TST) in Antrim was not in place prior to our engaging in the Transforming Your Care (TYC) consultation. We did not have the benefit of the turnaround team's thoughts at that point on issues relating to the Causeway Hospital, the west and so forth. We agreed to appoint a turnaround and support team in the Northern Health and Social Care Trust in December 2012 in response to a lack of sufficient improvement in the emergency department waiting times, especially the number of patients waiting in excess of 12 hours and the significant number of patients waiting longer than four hours. It is an external expert team with a remit to support the trust to help turnaround performance in critical areas, and it is working alongside the support already given by the HSCB and the Public Health Agency (PHA).

The TST will undertake an analysis of the challenges faced by the trust and make recommendations on the changes necessary to improve performance. The team will work with the trust to produce a robust strategic turnaround plan and will provide the necessary advice and assistance to enable the trust to execute the plan effectively. It is being led by Sue Page, the chief executive of NHS Cumbria, and the other team members are Ros Fallon, who is a registered nurse and the director of performance for NHS Cumbria, and Matthew Cooke, a professor of emergency medicine at Warwick Medical School and the head of clinical systems design at the Heart of England NHS Foundation Trust. The team is directly accountable to the permanent secretary and reports progress on its work directly to him through regular meetings. Their views will have some impact on the Causeway situation and how we move that forward, which is, of course, associated with TYC.

I am happy to get into the detail of questions, Chair, if you are happy to move on.

The Chairperson: I do not know whether you want to deal with it separately, but you mentioned paediatric cardiac issues first, so we will probably deal with that. You apologised to Jim and I yesterday, and you apologised in the House, and again today. However, we sent a number of letters, and it is important to find out whether those letters got as far as either you or Andrew. We sent the letters on 18 January and 28 February, and we did not get a reply. The point that I was trying to make is that we have worked — both us as the Committee and you as the Department and Minister — on a lot of issues, and we seem to work well on them. For me to get information from parents saying that the announcement was made does not sit right.

We have had pre-briefings with officials on consultation exercises. First, why were the letters not replied to? Were you and Andrew aware that the letters had been sent and, if so, when? Why were we not consulted before the decision on the framework document? It is normal practice for the Department to brief the Committee on any outcome, so it seems to me as if protocol was broken in this instance.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): Obviously, the process is still at an important stage. The conclusion of the framework for analysis is an important stage, and we have recognised that that should have been the subject of engagement with the Committee. That was probably the time to make a response to the letters that you mentioned. We need to put that right, but the assurance is that the points you have made and all the concerns that have been expressed are absolutely part of a process of consideration of the issues so that the next stage can begin, which is to look at the eight options that the Minister mentioned and go into the development of a preferred way forward. That process is now the key stage and has to be guided by all the principles that have been established in the consideration of the framework. That is still a major process. It is not in any way prejudged. That will lead to an analysis for the Minister to consider, and we need to commit now to having an informal session with you as part of that process. That is the next step, and, through the Minister, we will get you a reply to the points made in the two letters that you mentioned.

The Chairperson: Did you see the letters?

Dr McCormick: Yes, we saw the letters.

The Chairperson: OK.

Dr McCormick: The letters are being handled in the normal way, and if we have missed the right time to come back to you, we apologise.

The Chairperson: I am not trying to catch you out. I am just trying to work out protocol and procedure on any issue. A commitment was given, publicly and privately, that we would have this, so if some of the letters from us are not getting to that level, you need to look at that. We are all aware that this is a very sensitive issue, and the Committee even took a motion to the Floor on it. You can guide me: are we entitled to get any of the information on the eight options, or is that still internal to the Department?

Dr McCormick: That process involves the working group, the confidence of which is very important in this context. There is nothing to hide, so let us get back to you on that properly.

Mr Poots: I have always operated on the basis of having as much transparency as possible. If you are looking for it, I would like to provide it. We will seek to deliver that for you as quickly as possible.

The Chairperson: Thank you, Minister. Can I suggest that, when you are thinking about who needs to be informed about stuff, the Committee is in that loop? Hearing it on the radio, seeing it on TV or having parents contact you in a bit of a blind panic does not help.

Mr McDevitt: Of the eight options that have been identified in the post-consultation document, three of them — options 2, 3 and 5 — would mean:

> *"there would be no surgery or interventional cardiology in Belfast."*

That is either because it would all happen in Dublin or all in GB or in Dublin and GB. If I have read the options correctly, any of the other five mean that surgery and interventional cardiology would continue to be carried out in Belfast. Perhaps colleagues can confirm this to me. Minister, is it not reasonable that we focus on the five options that mean that we maintain some surgery or interventional cardiology here in Belfast?

Mr Poots: We have found this to be very challenging in that I am getting some fairly strong directions that we should be moving away from carrying out surgical intervention in Belfast. I have not accepted that. I have challenged that, and we need to identify the right solution, which is to ensure that all children receive the best possible care and surgical intervention that might be available to them. Is that option available only in England, is it available in Dublin or will elements of that option be available in Belfast? I want to ensure that we exhaustively test what we can deliver in Belfast as my first option. I then want to move to Dublin and acquire as many services as possible there that we cannot deliver in Belfast before we move to the English model. Currently, 140 major interventions take place — 100 in Belfast and 40 outside Belfast. There will always be a reliance on England to some extent for really complicated pieces of surgery, but Dublin can perhaps take some of that away from England. We are still working on how much of that can be kept in Belfast, and it is a challenge — I will not put it as anything less than that. However, I want to maintain a service in Belfast that will, practicably, meet a substantial amount of the needs of the families with children with PCCS.

Mr McDevitt: I welcome the Minister's comments. It strikes me that option 1 is to continue with the service in Belfast, but option 8 is a very exciting and ambitious option. It is a bit like the cancer centre for paediatric cardiac services. Option 8 states:

> *"Paediatric Cardiac Surgery and Interventional Cardiology commissioned primarily from Belfast with an increase in the number of procedures in Belfast by bringing children from elsewhere to make the local service sustainable / a Centre of Excellence."*

Options 4, 6 and 7 seem to be about building Belfast into an even better network than it is today and either giving the opportunity for surgeons from GB and the Republic, as option 7 suggests, the opportunity to work in Belfast and grow the skill set here, or enhancing collaboration, as you said, on an all-island, British Isles or these-islands basis. It strikes me that the majority of options show Belfast

in an ambitious mode, saying that it has a future as a surgical and interventional centre. Could I, therefore, press you a little more, Minister? Given that there are so many options that give Belfast a bright future, could you give us a commitment that you will prioritise those options over the next few months and only ever consider options 2, 3 and 5 when you have exhausted the other five options?

Mr Poots: It is fair enough that we consider the options that take surgery outside Belfast, Northern Ireland and Ireland only after we have exhausted what we can do locally. I certainly aspire to that. Although it is critical that children receive the best possible care, the local dimension is very important because many of the parents have other children, and many of the parents are not fit to travel because they have just given birth, have gone through a caesarean section and so forth, so they are separated from their child. Other important issues cannot be overlooked when you arrive at a decision. My clear preference at this point is that the Royal Belfast Hospital for Sick Children becomes part of a network to deal with paediatric congenital cardiac care with the rest of Ireland. That network can use the British Isles network when required. So although complex procedures may travel to Dublin, more interventional procedures may be able to be done in Belfast, with people travelling from Donegal to Belfast as opposed to travelling to Dublin. We need to apply ourselves to getting a solution that meets the needs of the children. Nothing else should be of any particular interest to us. It is about meeting the needs of the children.

The Chairperson: Minister, I am conscious that you are here to discuss TYC, but it is important that we also discuss paediatric cardiac surgery. Members need to be aware of that. You said that something will happen within the next couple of months. Can give us — maybe not even today — a definite time frame for the next stages? A lot of people responded to the consultation; it is probably one of the best consultation responses. It is a very emotive, personal and sensitive issue. I would like to leave here today knowing what the next stage is rather than just hearing about it. So can give us the outworkings of that?

Mr Poots: I am conscious that we indicated that we were looking to make a decision by the end of February. I suppose that what was suggested to me at the end of February was something that neither the Committee nor the community would have found acceptable, and I certainly did not find it acceptable. So more work is needed to find a place that is acceptable. The fact that we have not come to a decision is probably positive in that sense, because had we come to a decision based on the recommendations, it would have caused huge consternation.

I will continue to work with all the team to seek to get to a point at which we deliver a solution that deals with all the clinical issues — those are very important — and does so in a way that takes account of the specific needs. That stretch of water, albeit a small stretch, is an important one, and it has a huge impact on parents and those who provide care for children. A lot of these children can end up in hospital for many weeks and months, and their parents are taken away from their locality and perhaps their other children because they have to live elsewhere. They also have to put in place child-minding arrangements for their other children to ensure that they go to school and so forth, which puts huge pressure on the wider family and friends.

Clinically, the argument can be made for moving to the English model, and issues with flights, and so on, could probably be overcome, but that is not the sole issue. We need to ensure that, if we come up with an alternative involving Belfast and Dublin, it comes pretty close, clinically, to the service that can be provided in England. That challenge still exists, and we have to get to it.

The Chairperson: In fairness, that is very reassuring. I think that a lot of the people involved — parents, family members and clinicians — listen quite closely to the Committee and take on board the minutes. You have probably reassured people that you are looking at all the options to ensure that you get the right outcome that keeps everybody happy.

Mr Poots: I am in the position that, on the one hand, the public are saying, "If you send children over to England and take surgery away from Belfast, you will cost the lives of our babies", and, on the other hand, I have people on the clinical side saying, "If you do not do that, you could cost the lives of babies in Belfast". It is an invidious position, but I chose to take this position even though I could have avoided it.

The Chairperson: We know that you will make the right decision.

Mr Poots: I am attempting to get there. I have good people working on it, and I know that they are getting the message about what we want to achieve.

The Chairperson: If you get an opportunity, can you give us an idea of the time frame? The cynic in me says, "As long as this goes on, services will be run down, so the decision to move will be made easier".

Mr Poots: I understand that. That has happened in the past.

Mr Beggs: You just mentioned that clinicians said that there is a risk if you do not move operations elsewhere. That obviously is not what parents are saying. Many of them have said that they are aware of cases in which children may not have survived but for local surgery. I am conscious that that is not what came across in the consultation because the service in Belfast is deemed to be safe at present. So what is going to change suddenly to make it unsafe?

Mr Poots: The important words that you used are "at present". If we do not get our heads rounds this one, the words "at present" will be removed that sentence in respect of the service being safe and sustainable. So we are looking towards the future. I will bring John in at this stage to give you a bit of the background and explain why, if we just keep doing what we are doing, we will hit problems. That is why we need to work at achieving a solution here.

Mr John Compton (Health and Social Care Board): Thank you. Whatever the outcome, as the commissioning organisation, we will be commissioning a successful cardiology service for children in Northern Ireland. That is the important issue and the sole objective.

It is important to understand what we are talking about with the issue of safety. Large numbers of youngsters use the cardiology service routinely and straightforwardly, and we want to commission that service successfully. Small numbers of children need intervention: about 140 per annum across Northern Ireland, with a further 40 requiring interventional cardiology. For some considerable time, we have used England, and we have been using Dublin regularly for the last period of time. The numbers are small, and that is the core of the problem. How do you run a service 24/7, seven days a week that meets all those standards? That is not without difficulty or complexity. Professional advice tells us that surgeons doing interventional work should be doing in the order of 125 of these procedures per annum individually to maintain skills, expertise and the ability to absorb new techniques and arrangements.

So we have a small number of children across Northern Ireland, and we have to run the service seven days a week. You need teams to run the service seven days a week, and the numbers become problematic not only at the surgical level but at the post-surgical level — for example, intensive care and so on — and the other skills that are involved such as specialist nursing skills, specialist physio skills or whatever is necessary.

That is the conundrum. We want to try to make that a successful solution for the population of Northern Ireland. We are not blindly charging towards a situation in which you cannot do things in Northern Ireland. On the other hand, as the Minister has quite reasonably pointed out, you cannot ignore some of the facts, one of which is that the numbers involved are quite small. You also cannot ignore the impact on parents, and we are not attempting to do so. Parents have been very much involved in the working group. They are entitled to attend when the working group is in session in order to understand and to listen to what is going on, and they do that on many occasions. To answer your question: it is a numbers game that will become problematic, not today but three to five years down the line.

Mr Beggs: Should you choose to remove the service from Belfast, there is the potential for knock-on effects, which the Minister acknowledged yesterday. I am aware of concern, particularly around paediatric anaesthetists. Minister, in what other areas could there be a knock-on effect, making it more difficult to attract specialists in the future should the service come to an end?

Mr Poots: We need to recognise the fact that our population is quite small, so many of the more complex procedures take place outside Northern Ireland. Bone marrow transplants and many cancer services go over to Birmingham. We also still use facilities in London extensively for children's services, so quite a lot of services are met outside Northern Ireland. The difference with PCCS and perhaps other services is that many PCCS cases are emergencies. Cancer treatments, for example, although desperately traumatic for any parent, are planned in many instances so are not emergency but elective treatments and do not apply as much pressure on a family.

I have certainly been picking up that there could be problems with paediatric anaesthetists if you remove the PCCS service because there is not the same requirement for them. That would have a knock-on effect on other services because fewer paediatric anaesthetists would be available. That certainly has to be taken into account when a decision is arrived at on the overall well-being of the children's hospital.

Mr Beggs: What other services could be affected?

Mr Poots: Obviously, if you do not have the relevant number of anaesthetists, surgical procedures could be affected.

Mr Beggs: Could the full service start to decline at that point?

Mr Poots: I would not say the full service, but you could be challenged to carry out the extent of surgical procedures that are currently available.

Mr Beggs: I hope that you will take all things into consideration.

Mr Dunne: Minister, is there an issue about the consistency of standards across the jurisdictions? Is that an issue of concern to you?

Mr Poots: In Northern Ireland, we should aspire to the highest standards. If there are areas in which we are falling short — on occasions, there are — we need to look at how we can bridge that gap. I spoke at a Northern Ireland Confederation for Health and Social Services (NICON) conference last week, and I indicated that I did not regard some things as targets but as standards. Sometimes, people confuse targets with standards, and we need to ensure that, if we set a standard, we work very hard to achieve it. If we are falling short, we need to identify solutions on how we can achieve the standard that we have set ourselves. Standards are a good thing. They will drive people to excel, and we always need people in our Health Service to excel. In most instances, the message that I get from the public is that we have a Health Service that is excelling but that occasionally falls short.

Mr Dunne: Is there an issue about consistency? Obviously, you have had negotiations with Dublin. I know that you have had several meetings. Is there a risk that there could be a difference in the standards of care? Surgery in cardiac services for children is a highly skilled level.

Mr Poots: The recording of standards is sometimes not as strong in the South as it is in GB. That was an area of concern to us, and we have been engaging in discussions to give that quality assurance. I will ask John to pick up on that.

Mr Compton: The point is well made. We are confident that the standards that apply in Dublin are entirely adequate and meet the standards. We have asked them to report into the central cardiac audit database (CCAD), which contains the results of cardiac surgery. Quite rightly, cardiac surgery is a heavily scrutinised intervention across the British Isles, and Dublin is part and parcel of that system, so the standards will apply. We would not be interested in commissioning services from somewhere that has a poorer standard than ours. I reassure the Committee that we have been working quite energetically.

Mr Dunne: Are you confident that the standards will be equitable?

Mr Compton: Absolutely, yes. It is important to remember about scale. We are dealing with relatively small numbers, and the rest of the island is dealing with fairly large numbers. These issues are numerically driven at a certain level, so I am confident. We derived the options from working closely with parents and professionals, and everyone knows what the options are and has signed off the framework agreement. The proposal will be sent up to the Minister. All of that was well known, well established and well agreed, so there is nothing that was not an agreed position from parents, professionals and the commissioning Public Health Agency side of the house. We are keen to work as closely as we can with all parties to get, as I said, a very successful solution that sees a strong cardiological service that is properly networked and available for the population in Northern Ireland.

Mr Dunne: Are skills shared between Dublin and Belfast on this surgery?

Mr Compton: Yes.

Mr Dunne: So you have some evidence?

Mr Compton: Yes.

Mr Dunne: Good. Minister, was there mention yesterday that there was to be an upgrade of facilities in Dublin? I think that that was mentioned fairly briefly.

Mr Poots: A newbuild has been agreed, so an entirely new hospital is being built. When that hospital is developed, the facilities will be top of the range.

Mr Dunne: I take it that those are theatres?

Mr Poots: It is a brand-new hospital so it will —

The Chairperson: Ours could be top of the range if we ever get the new women and children's hospital. *[Laughter.]* You walked into that one.

Mr Poots: The full range of services will be available; the issue is what will happen and what will Dublin's capacity be to help us in the interim. That was one of the challenging issues raised in what was being suggested to me about a month ago.

Mr Dunne: When is the new hospital scheduled to open?

The Chairperson: North or South?

Mr Dunne: In the Republic — in Dublin.

Dr McCormick: It is several years away.

Mr Dunne: It is a bit like your hospital, then.

Mr Poots: The site has been located and has just got the go-ahead.

Mr Compton: I should say that, despite the fact that a new hospital is, as we understand it, being built, the current paediatric cardiac surgery and intensive care facilities are entirely suitable. If you are just looking at physical environment, there are other issues in the children's hospitals in the other jurisdiction that need more immediate attention.

Ms Maeve McLaughlin: From the visit to the children's unit, the view was picked up that Dublin was working over capacity and that its provision was stretched. I want to confirm that that is the case. In light of your comments about the new hospital, and bearing in mind that Dublin may need to work in partnership for the provision of this service across the island, will the new hospital have the potential to negate that need?

Mr Poots: Dublin's being stretched may be of assistance if we do not have enough surgical procedures for our doctors. It would be ideal if our doctors were working in a network in which they could carry out procedures in Dublin and still carry out procedures in Belfast. That is where we want to be. They would have the requisite number of surgical procedures to maintain the skill set that John said is so important. There would still be the opportunity to carry out an element of that surgery in Belfast, with the more complex procedures being carried out elsewhere. That is a huge ask and a huge challenge, and we have not got there yet, but those are some of the issues that we will be discussing.

Ms Maeve McLaughlin: Gordon raised an issue about standards, and you referenced their recording, which may not have been as robust as one would like. However, work has been done on that. Is the Department encountering any specific obstacles about developing that all-Ireland resource?

Dr McCormick: It is a matter of working with the South to ensure that the options are all viable. Given the stretch on their resources, there would have to be some recruitment. If we were heading for an option with a greater dependency on services in Dublin, they would need to build up their staffing levels to match that. We are working with them to establish the limitations and see what the possibilities are so that whatever emerges as the preferred option ends up being deliverable.

We have to look at that to be sure that we are making a realistic and proper assessment of those issues, but we cannot buy anything from them unless and until there is a decision. The key issue now is to make sure that the next stage of the process happens properly and that all options are considered.

Ms Maeve McLaughlin: I am picking up that recruitment could be an obstacle or an issue.

Mr Compton: It is important to put on record that, while it is a fact that it is only in recent times that the paediatric surgery down South has reported to the Central Cardiac Audit Database (CCAD), at no point prior to that was there ever any suggestion that, in any way, the standards of service were other than very adequate. It is important to state that there is not an issue. It may have been reporting and auditing things differently, but at no point was there an issue of it not being at an appropriate standard.

As Andrew indicated, the issue is that, if we were to move in that way and ask it to do extra activity, it would, of course, need to increase in size. If we simply put in extra volume without extra resource, there would, of course, be a stress and strain on its side of the house. It is organised to do the volumes that it is organised to do. If it is asked to take on more volume, part of whatever contractual arrangement we might have would be the price that we would pay for that. The price that we would pay would turn into additional staff. The more serious question is this: would they be able to recruit staff? We do not think that larger units will have anywhere near the same difficulty in recruiting staff as smaller units. In that regard, that area should not have a particular difficulty or problem with recruiting staff. On this occasion, the problem that we face, on the other side, in respect of the scale and size of unit, is not a problem that they face on their side.

The Chairperson: I want to talk about Transforming Your Care, Minister. A number of us sit on all-party working groups up here. Yesterday, there was a meeting of the all-party group on mental health, which was useful on the back of your statement in the morning. The issue of carers, and especially carers who support a loved one with a mental illness, came up. Those carers are saying that mental health services do not involve them in care planning. You are talking about having more services in the community and home being the hub of Transforming Your Care. The issue of carers in general has come up a number of times over the years, specifically carers who deal with people with a mental illness. How do you or the Department plan to improve the recognition of carers as an equal partner so that they can be involved from the outset in whatever care is happening, whether that is in the home or in the community?

Mr Poots: As TYC moves forward, carers in general are bound to have a greater role to play. One of the issues that I highlighted yesterday is that one size does not fit all. The message needs to be driven through to the trusts very strongly that they must apply flexibility and not ask the impossible of their staff by setting in place a structure that does not enable that flexibility to be applied. The people best placed to make the case are very often the carers, because they know the individual and his or her needs better than anybody else. Under Transforming Your Care, carers will inevitably have a greater role to play. Chair, I suppose that the question that you are really posing is this: how do we structure this to ensure that carers have a greater role?

Mr Compton: I will make a couple of points about the mental health side. I think that 99 people will be leaving hospitals. We know those 99 individuals. The plans for each of those 99 individuals over the next couple of years will involve close contact where appropriate and where there continues to be family engagement. That is a central issue. There is a straightforward commitment in that regard.

On the more community-based services, the provision of support services that mean people avoid going into hospital has been very successful. If you talk to the crisis intervention teams, you will hear that there is a considerable acknowledgement that that has been a very successful strategy. That involves talking closely to parents and family members. On the commissioning of services, we expect to have a specification that acknowledges where carers are in the middle of all this. That requires them to be consulted, involved and engaged in the process as far as their individual family member is concerned. As the TYC process moves forward, we will see the commissioning specification changing to make sure that there is carer involvement.

As regards resettlement, we know all 99 individuals and their circumstances. That takes us directly to the families and key individuals in those 99 people's lives so that we can make sure that, whatever their tailored package, it is tailored in a way that has as much carer support and involvement as is practicable. We know this to be very complicated, particularly in the field of learning disability. People are, very rightly, concerned about the issues that will emerge, so we will handle all of it with some sensitivity.

I take some confidence from the fact that, on the mental health side, we have already successfully placed lots of people from long-stay institutional care outside hospital. There are a number of successful facilities that Committee members have probably been to see. The design and engagement in that regard has involved sensitivity.

The Chairperson: I touched on GP contracts yesterday. If the vision of Transforming Your Care is about taking people out of acute care and into secondary and primary care, it is important that GPs not only buy into it but are a key component of it. We, as a Committee, have done some stuff on the whole issue of GPs being proactive in early intervention and prevention. Therefore, it is a concern when we hear that the issue of GP contracts, although a side issue, could have an impact on Transforming Your Care if it does not go right. In my view, it could.

One of the issues that came up again yesterday is just how important GPs are in the whole issue of mental ill-health. People are asking blunt questions. How will GPs be given adequate resources and time to train so that they can be at the heart of Transforming Your Care? How do we ensure that other professionals at a community level work closely with the community and voluntary sector as equal partners? I represent a constituency that has a strong community infrastructure. I know that that is not the same in every constituency. However, how do we ensure that the community and voluntary sector is seen as an equal partner and that we are not just dumping a lot of work on GPs?

Mr Poots: The GP contract is being negotiated on the basis that there will be a 1·5% increase in investment in GP services over the course of 2013-14. So, we are not looking at cuts; we are looking at an increase in investment. However, we believe that quality and outcome framework indicators in the contract are very important. We will have discussions on those things and how they can contribute directly to the delivery of TYC. I am picking up from GPs that they have a lot of additional work, especially over the past two years. A lot of them are saying that they are coming under too much pressure as things stand. We need to hear what they have to say, strip out that which is less meaningful, identify the core issues and seek to deal with those issues in a meaningful way so that we can move forward with GPs on board. That is where we are trying to get to. As I indicated, this is not about any cuts or reductions in funding. There is actually a modest increase. It is a modest increase, but it is an increase. The challenge that faces us is how we work with GPs on delivering the best possible services.

In essence, GP facilities can be the hub from where a lot of the community services are dispensed. The closer association that allied health professionals, social care, district nurses, and so on, have with GP practices the better. Integrated care partnerships are absolutely critical to moving forward with TYC, because they have that multidisciplinary element and, at the same time, the local perspective. That can bring those things together to create a very intuitive and innovative means of providing services in the local community.

Mr Compton: I will say three things about how GPs will be supported. First, we will provide a training opportunity for GPs in the integrated care partnerships and lead GPs to look at a new role and a new way of working. Part of the funding will be for secondment opportunities to enable a GP to leave a practice, for example, for a half day a month, so that the practice can run and they can come out of the practice and do all that. That will be important.

The Chairperson: So they don't have to cancel clinics.

Mr Compton: Correct. We are also in the process of completing the support to general practitioners in each of the LCG areas and deciding who will be the main liaison person with the 25-plus GP practices in each of the ICPs. A lot of investment is going in to enable that, because we understand only too well that you cannot simply exhort people to work harder without giving them the facility and ability to do so. That is well recognised. A series of actions have been discussed with a number of the senior members of the GP leadership, and, although there is a contractual thing that we hope will get to a successful conclusion — *[Interruption.]*

The Chairperson: When will the negotiations on the contract happen?

Mr Poots: When we get agreement. How long is a piece of string? Essentially, we want to bring that to a conclusion sooner rather than later.

Mr McCarthy: We mentioned GPs to the Minister on the Floor of the Assembly yesterday. I have met GPs and had letters from them, one of which is before us this morning. You mentioned the 1·5% increase in investment, and that will be very welcome, but what about the minimum practice income guarantee that is under threat? Many of the GPs have depended on that up to now to keep a good service in their locality. It seems to me that, if that is taken away, you will be cancelling out that 1·5% increase.

The other question is on the independent advocacy service for people with mental illness, learning disability, autism and dementia. What will that be during the Transforming Your Care period?

Finally, I saw a statement from the physiotherapy people yesterday about the self-referral that is practised in England, Scotland and Wales but not here. It has been very successful and helps to reduce waiting time and so on. People do not have to go to GPs or medical practitioners to be referred to physiotherapists. That could be implemented.

Mr Poots: We are a sharing group here, and so I will take the last question, Andrew will take the first one and John will take the second one. You asked about the physiotherapists, and I have said for some time that we need to maximise the services that we get from allied health professionals because, in my opinion, they provide good value for money. We are looking at the opportunity of prescribing and so forth. We are also moving to a position where podiatrists will carry out surgery in Northern Ireland; that is practised elsewhere in the UK but not here. So, if those things are happening elsewhere, there is no reason why they cannot happen here, and if they are successful elsewhere, there is no reason why they cannot be successful here.

I am not content just to do what they do elsewhere. I want our allied health professionals to be in a position to trial things and for others to follow, as opposed to us waiting for others to do those things and us to follow. We will be very happy to follow up on those issues to ensure that we maximise the services from our allied health professionals. Andrew will pick up on the GP question, and John will deal with advocacy.

Dr McCormick: As you mentioned, one of the proposals in the Department's consultation for the contract in Northern Ireland was to phase out, over seven years starting from 2014, the minimum practice income guarantee, which is one of the complex elements of the formula. The reason for looking at that option was so that more of the funding would be distributed according to need. Targeting deprivation was the underlying intention. The General Practitioners Committee (GPC) and the British Medical Association (BMA) have sent back some arguments against that, and those are still being considered. Further advice will go to the Minister on that in due course, but this needs brought to a head quickly. We have seen similar letters to the one that you mentioned, but I am wary of any risk of unintended consequences. The reason for looking at it was good intention, but the question is this: does the analysis of what would happen deliver what we are trying to achieve, which is to align funding with need? That is why we will be doing it. If that is not working, the policy will need to be reconsidered. The consultation closes on 22 March. After that, there will be a need to consider all the points made in consultation and to continue to engage with the GPC to try to get to an agreed position.

Mr McCarthy: It seems to me, from talking to the GPs, that it is vital to keep the service in the locality going and up to a standard. If it is taken away, patients will be at risk. That is the worry. If you are to have another look at it, that is good news. I agree entirely with the Minister, but you have not said that we can introduce the self-referral here and now. What is stopping us?

Mr Compton: We are expecting to have a pilot arrangement for self-referral. We have been talking to the physiotherapy people about that, and that is on its way. We will look at that and evaluate where we are going with it.

We will continue to support advocacy. When we make major changes anywhere — for example, people coming out of institutional care on the mental health side or learning disability side or with older people — advocacy is a commonplace issue for us. We use it a lot, and it will continue to be very much part and parcel of how we handle services. We want to demonstrate that there is a genuine

sense of independence for individuals and a genuine third party to whom the individual can say, "I am not quite sure that this works for me". That third party will be able to broker on their behalf. So, there will be a very strong commitment to continuing the well-established advocacy arrangements.

Mr McCarthy: Finally, I will reiterate what has been said about carers. They are vital, and I see every day what carers have to do. It is up to you to deliver.

Mr Compton: We accept that, and one of the key messages in the consultation was to pay real and serious attention to the needs of carers. There will be no issue with that.

The Chairperson: The honourable Member for South Down, Mr Wells.

Mr Wells: Thank you, the honourable lady for West Belfast. I raised the issue of residential homes yesterday, and you dealt with that, but you also said that payments would be made to make certain that no one was worse off as a result of any decision to close a residential home and move the residents. Could you give us a little bit more detail on that? That was the first time I heard that mentioned in the context of Transforming Your Care. What are the mechanics of that proposal?

Mr Poots: We need to move away from the concept that we are closing residential homes through TYC to the concept that we will require fewer residential homes as a result of providing people with more favourable and better options to stay in their own home. The consequence of the first point is the lesser requirement for residential homes. How do we then handle the reduction of residential homes? It is important that, in handling that reduction, we deal with people in a fair and compassionate way. Elderly, vulnerable people will have become very used to a facility as their home for a considerable time, and we will be putting them through some upheaval. We need to acknowledge that at the outset. We must minimise that upheaval, and that requires us to do a number of things. First, we need to look at homes that have considerably fewer permanent residents; hence, fewer people will have to go through that upheaval in the first instance. Secondly, we need to create the opportunity in the process for many people who have developed relationships with other long-term residents to stay together. So, we must identify facilities that can accommodate several people as opposed to scattering people by taking one here and another elsewhere. Thirdly, we need to ensure that they do not have a financial burden or concern imposed on them as a result of the move. Therefore, where we are unable to identify facilities that do not have top-up payments, we make a clear commitment that trusts will meet the top-ups for any individual who moves from a statutory residential home to a private one that operates a top-up system.

Mr Wells: So that person will be in exactly the same financial position as they would have been if they had stayed where they were?

Mr Poots: Correct. Of course, that would not apply to people who are coming into, but are not currently in, residential homes. That is different, but we want to drive down significantly the number of people going into residential homes.

Mr Wells: Yesterday's statement said that 50% of statutory homes would close. I know from my own constituency that some of them are in a very poor state of repair, and large capital investment would be required to bring them up to standard. You have spent money on others quite recently. What do you envisage those new units being used for?

Mr Poots: The proposal is not that all residential homes will close. We are looking at closing a majority of them but not them all, so facilities will survive. Facilities will also be required for respite purposes. We will require considerably more respite services if we keep more people at home, because there will be times when people just need that break to enable them to carry on. We do not expect people to be carers seven days a week, 52 weeks of the year, so we will require more respite services. I also know that respite services apply not just to the frail elderly; they apply to people with learning disability and other long-term conditions that mean they need full-time care.

Mr Wells: You said yesterday that the final decisions rested with each of the trusts, which will look at their stocks of residential homes and make recommendations and consult before reaching final decisions. Will that be done separately or will there be a cut-off date by which they must all come to a conclusion?

Mr Poots: We are looking at a three- to five-year process, so some of it will happen immediately and some not for three or four years. This will not happen overnight. The process will happen over time, and it will be up to the trusts to consult locally on each of these.

Mr Wells: When can we expect to see the trusts start to unveil what they intend to do?

Mr Compton: The first proposals for changes in residential care will come through in the incoming year. The timing is important here because this is about changing the model of care. As the Minister indicated yesterday, there are about 479 housing with care places opening over the same timescale. The timing of their opening and the timing of the increase in the community packages will be material considerations in creating a timescale for us to be able to take different approaches to and uses of the existing residential care. I expect proposals to come forward in the 2013-14 year for a number of residential homes to cease functioning. The debate and consultation will be about how, not why, it is done, because the why has been stated, if you like.

Mr Wells: Are we still in the position that any staff employed in the homes affected will be relocated, if they wish to be, within the trusts' labour forces?

Mr Compton: Clearly, if someone has skills in providing care and support for older people and we are going to need community services, we are going to need people to do that, so there will be every opportunity for that to work. However, that tends to get in to a very detailed argument about a detailed individual set of circumstances. First of all, we have successfully closed elderly person's homes in the past, and we have not done that in a way that has been problematic or overly difficult for staff. I expect exactly the same approach to follow through as far as all of that is concerned, because we will need people to provide care and support.

Mr Brady: I know that you have dealt with the GP contracts, but this is just to reiterate it, because I have had meetings recently with local GPs and will have some more on Friday. The letter that we have refers to:

> *"the looming imposition of the harshest GP contract in a generation."*

That is fairly evocative language by any stretch of the imagination, and the GPs who I have spoken to are certainly not happy campers. There are other issues locally about the centre that may or may not materialise in Newry, for instance, but that seems to be an issue. I just reiterate that, because there are issues in terms of the numbers that they are dealing with. There are possibly more complex conditions for some people, including the provision of interpreters, for instance, because there are more and more people from the European Union coming in. All of those issues, presumably, cost a fair amount of money.

On another issue, I know that there has been a lot of talk about the 180 beds. I listened to you on the radio on the way down here this morning, John, skirting around that issue, if that is the best way to put it.

Mr Compton: I thought that I was answering the question.

Mr Brady: I was driving at the time; maybe I did not catch it all. It seems to me that what the Minister was talking about yesterday was the fact that, if you have the infrastructure in the community, fewer people need to go to hospital. Therefore, by definition, you are going to need fewer beds if you have an effective community infrastructure to prevent people having to go for acute care. That message did not seem to be getting through, because there was a nurse on, and you said that you and she have had many discussions and you agreed to disagree. I think that is the nicest way to put it.

Mr Compton: There are two things there. You are right; the 180 beds are a by-product. If you manage long-term conditions in a different way, people with diabetes or chronic obstructive airways disease are able to be managed at home, and individuals who may have been in hospital four, five or six times are no longer going to hospital with that regularity, by definition, you need fewer hospital beds. The modelling exercise suggests that it will be 180 beds. It will be what it will be. It might be 170 or 190 — whatever it turns out to be — but, in that sort of situation, that is quite correct. That should not be confused with the fact that, when we look at efficiency in how we use our hospital beds, that is a separate stream of activity. We think that the 180 beds will come out naturally because of a different model of care. That would be distributed across the region. It is not earmarked for a given

facility as such. It is a reflection of the fact that, if you change the model and the numbers of people coming into hospital, you change the need for the beds.

Mr Brady: I will finish on a positive, parochial note, because Daisy Hill got a very positive mention yesterday for its use of telemedicine. When the Committee went there in September 2011 we saw a demonstration of that. I think that what came out yesterday alleviated worry and lessened a lot of the scaremongering. Maybe that emanated from the initial pronouncements around Transforming Your Care.

Mr Poots: The hospital without walls concept should assist us to help hospitals that are smaller facilities, which would face more challenges under those circumstances. Innovation and technology can help sustain local services, which is a benefit.

As for the GPs, at this stage, we are not imposing anything. We are engaged in negotiation, as they have done in Scotland and Wales. England is the only place where there has been an imposition. We want to arrive at the Scottish and Welsh position by negotiating a solution. I suppose that it takes two to tango, and we will have to work with the GPs to attempt to achieve a solution as opposed to imposing one. That may be the fallback position, but it is not what we want to do.

Mr Brady: There has been a positive demonstration of the networking concept between Craigavon and Daisy Hill. I will finish by saying that I managed to ask questions on Transforming Your Care without mentioning welfare reform. I will leave it at that.

The Chairperson: That amazed me, Mickey. I have a question on welfare reform, but I will come back to it.

Mr Dunne: I have just a few points. The role of integrated care partnerships was mentioned yesterday. Will you clarify that issue? I take it that GPs will be involved in the care partnerships. How are those progressing? Will it be a case of pushing for local services and making sure that they are consistent across the trusts? Will that be part of their role?

Mr Poots: Yes. I will bring in John to elaborate on that a little. We are making substantial progress on integrated care partnerships. They are multidisciplinary, so there will be a wide range of individuals covering the key areas. That will enable us to keep more people in the community and provide them with the care and support that they need to avoid hospital admission. As I indicated yesterday, we hope to have a couple up and running in each trust area over the next few months, with all 17 up and running by this time next year. I heard one interviewer say yesterday that you cannot expect to have all the issues around the frail and elderly and long-term conditions dealt with within the year, but that is not what we are proposing. It is a course of work that is commencing. Again, the local solutions will provide the evidence. People will look at best practice in other areas and seek to ensure that they are delivering the best possible service. John, do you want to cover that in a little more detail?

Mr Compton: First, GPs represent a key component part of integrated care partnerships. Integrated care partnerships bring the independent contractor side of HSC, which is general practice, together with the directly managed side of HSC and voluntary organisations. It is about that network; that is what the concept is about. There will be 17 such partnerships across Northern Ireland. We expect nine of them to begin to function fairly soon in 2013-14, with one to two in each of the LCG trust areas, and going ahead as quickly as practicable thereafter.

In the first instance, they will concentrate on services for the frail and elderly, respiratory disorders, diabetes and stroke services, as well as the end-of-life component for those conditions. In the first instance, they will have a clear remit and focus and will be able to look at one or two local issues that are important to a particular area. Part of this is about localising services so, although the whole of Northern Ireland and ICPs will look at those services, there will be some opportunity for local initiatives to flourish as well by looking at particular difficulties. Clearly, the Minister signalled that there will be investment to make that all occur.

I answered a question earlier about enabling general practitioners to feed into their practices by being involved in a training programme and the appointment of support general practitioner staff. There is a drive towards making that happen successfully.

Mr Dunne: Will the trusts be expected to carry out the recommendations of the partnerships?

Mr Compton: The local commissioning groups will write the specification for the service. They will then commission that service from the independent sector, the local trust and/or the local voluntary provider in certain situations. They will have a small performance matrix that looks at how the money has been used to provide services. For example, for end-of-life care in nursing homes, they will want to be able to track that the number of people leaving nursing homes and going into hospital for end-of-life care is reducing, because for an individual and their family, it is much better, qualitatively, to have the end-of-life experience in the place that is their home at that point, rather than to be in the back of an ambulance and then go through A&E only to pass on within, perhaps, 24 or 48 hours. That is not that uncommon, and we do not think that it represents good quality.

Mr Dunne: I have a couple of other issues. We talk a lot about A&Es in Committee meetings. Minister, you provided a letter to the Chair in which some issues were raised. One specific issue concerned 25 February, when an overload of ambulances went to the Ulster Hospital. It was extremely busy: 66 ambulances and 247 new patients attended the A&E at the Ulster. Obviously, that is a significant overload. What measures are being put in place to address that?

Mr Poots: Diverts for ambulances have been put in place. Those are very important because the Ulster normally has about 55 ambulances. Is that right, John?

Mr Compton: Something in that order; yes.

Mr Poots: That 20% increase means a considerable number of extra beds would be required because around 80% ambulance calls end up with people being admitted to hospital. The hospitals and the Ambulance Service trust are looking at how they can become more adept in providing the diverts at an earlier point. As opposed to waiting until they hit the crunch point, they are looking to identify earlier in the morning that they are heading towards a crunch point so that they can get the diverts in place earlier. It is a bit of a challenge for a hospital that has a bit of capacity for absorption to agree that it will receive more people before another trust has hit a crisis point or problem point. Discussions are ongoing among the trusts on that issue in an attempt to reduce the numbers coming through the door.

There has been considerable investment to support the Ulster Hospital. We knew that it would pick up considerably more patients coming from the City Hospital's A&E not operating. John is continuing to work with the Ulster Hospital and seeking to meet its needs.

Mr Compton: In the commissioning plan, which is the one-year tranche of TYC — these things will all become one thing; they are referred to slightly differently at present — we propose the zoning of accident and emergency departments for Northern Ireland. That is sensible because, at the minute, people go where they go. There are sensible judgement calls. On some days, in parts of east Belfast, an ambulance will go towards the Royal. On other days, it will go towards the Ulster. We need to zone that up to get the actual numbers correct. We need to establish the capacity that each of the organisations can reasonably take. We propose to look at that to make sure that we do not bump into days when we get 66 or 67 ambulances, which is a problem for any hospital.

As the Minister indicated, we have negotiated with the Ulster Hospital a very sizeable amount of money in two tranches. Its problem has never really been much to do with the City Hospital; it has been more to do with the population that uses the hospital and the acuity of condition or illness. We know that it has had increased admissions, so we have substantially increased the resource available to it. It will take a couple of months to get the extra beds and staff in place, so we expect the performance to be in a different order. Those negotiations have recently concluded, so there is very active energy. The total amount of money going to the facility is in the order of £10 million across the whole year. That very sizeable investment recognises the complexities and difficulties that there have been. Underpinning that, we will look at the ambulance flows across not just the interface between Belfast and the South Eastern Trust, but across Northern Ireland, because that occasionally throws up problems whenever it falls the wrong way. The ability to arrive at emergency departments can be much more ordered and disciplined.

We have also commenced a piece of work with each emergency department that looks at the numbers of people who come in annually; the conversion rate, which is how many people come in and how many people are admitted; and the demographic growth. That will allow us at the start of the year to set a working number. We will see how that operates so that we do not get caught in a situation in which things run out of control. A whole set of actions are going on in the background to get us to a

much more resilient platform, whereby we ask only what is doable of an individual hospital and its staff who work the front door when it comes to numbers.

Mr Poots: I think that John is saying that north Down has an older population, as evidenced by the MLAs who represent them. *[Laughter.]*

Mr Dunne: I do not think so. It is all the Belfast people coming in — west Belfast, I think. Thanks very much.

The Chairperson: It amazes me to hear that the Ulster is under pressure because people from east Belfast are going there. That is an issue that we must look at, because the Royal is also under pressure. You would have thought that having a local population going to the Ulster would free up the Royal, but it is not. The issue is bigger than people just choosing to go to either the Royal or the Ulster.

Mr McDevitt: I echo colleagues' concerns about some of the implications for general practitioners. I will talk about some of the strategic issues in TYC and the question of privatisation, which it is fair to assume is the clear direction of travel in the social care sector. It is difficult to see a direction of travel other than one which will arrive, to a large extent, at greater service delivery by the private or non-public sector. That brings a couple of issues to mind. The first is how we make sure that we ring-fence the extent to which we want this to happen. How do we put in place boundaries to make sure that, five or six years down the road, another Minister or Executive will not seize the opportunity to take it to the next phase? Could we do what Scotland has done and bring in legislation? I would appreciate hearing the Minister's thinking on that.

Alongside privatisation is the issue of regulation. We know from a well-debated and polemic argument around reproductive health services that you can let stuff go off into the private sector and then realise that it is outside the regulatory framework. What proofing has been done across the whole spectrum of health and social care services to make sure that anything that would leave the NHS family as a result of TYC can be guaranteed to remain within a regulatory framework?

Mr Poots: Services that we procure will always remain in a regulatory framework because we have control of those situations. The concern arises where people procure services privately. Throughout, TYC holds dear to the concept of retaining a health service that is free to users at the point of need. We are engaging in TYC to ensure that we can maintain a service that is free at the point of need and make that service as widely available and wide-ranging as possible. We cannot always meet what everybody asks for at the same time, but we aspire to meet people's clinical needs. Use of the private sector is a considerably different concept from the National Health Service, which provides free healthcare at the point of need.

Particularly in parts of England and Dublin's leafy suburbs, there is large-scale use of private sector healthcare, where people acquire their own services. In Northern Ireland, we have not reached that point. I do not think that we want to go there, and the only means of avoiding such a situation is by providing quality healthcare so that people do not see a need to acquire services elsewhere. People acquiring services from the private sector on a large scale serves as an indicator that the health service provided is not working as well as you would like. Our orthopaedic service waiting list is not good. We want to get to a much better place. We will acquire orthopaedic services in order to drive those figures down. Hopefully, we will get to a point where we have a sustainable service whereby people are not waiting as long for surgery and are not in pain for months on end, running into years in some instances. That is a wholly unacceptable situation.

We will continue to buy cardiac surgery, for example, because, were we to bring in another full team, it would take us above the threshold of what we require. That would add a cost to the health service that would then have to be recouped somewhere else and would result in a diminution of services elsewhere.

The private sector can be used to the benefit of the health service and for maintaining the principle of healthcare that is free at the point of need.

Mr McDevitt: Thank you, Minister. I agree that you always have to have the option to be able to deal with pressures. That option may not be within the public service, and most reasonable people are content with that. A couple of questions arise from that. First, if that is all that we will ever use the

private sector for, why would we not put that in legislation so that a future Executive or Minister could not take a decision to change that?

Secondly, if I heard you correctly, you said that the fact that the public sector procured a service that meant that it was regulated. Can you guarantee that? For example, given the well-publicised procurement of services in the midlands in the Republic and the fact that the Health Information and Quality Authority (HIQA), as I understand it, is not yet operational, how can you guarantee that services are regulated to the standards that we would want them to be?

Mr Poots: That is an important point, particularly if we are going down the route of acquiring domiciliary care. Under Transforming Your Care, we want to ensure that people who are going into a person's home to provide care for someone else's loved one — someone who may be very vulnerable — work to the highest possible standards. We do not want people going in and doing things that they should not be doing, or not taking the time to do the work appropriately or properly. It is very important that that happens.

Perhaps Andrew will pick up on the robustness of the way in which we acquire services, which may not always come from the DHSSPS or the trusts but may be acquired from the private sector, so that standards can be maintained.

Dr McCormick: I will reinforce the point that the Minister made. The scope and the power of the regulation system covers everything that we deliver in the public sector or procure using public money. That is clear and, in fact, RQIA, as a regulator, spends a very large proportion of its time and effort in inspection and regulation in the independent sector. That is a function that it inherited from the old boards, but it is still a very dominant function. It is an area about which we have given account to this Committee before.

That guarantee stands, and the key question is whether regulation is working and fully effective. We need to bring together the inspection and regulation that is performed by RQIA as a statutory body and we need to make sure that professional regulation is effective. Consideration is being given to the issues in regulating the social care workforce, which is a further means of seeking to secure standards.

We must also make sure that we are as open, candid and transparent as possible, and that we can deal with good information that comes from patients so that we are aware, from every possible source, of where problems may be arising. We have to make sure that we are designing and overseeing a system in which regulation is balanced and effective. We cannot have a camera observing every single activity; there has to be proportionality. That depends on confidence in people at the end of the day. A lot of activity takes place on a one-to-one basis with no other observer.

Mr McDevitt: Andrew, are you saying that RQIA's jurisdiction extends beyond the boundaries of Northern Ireland?

Dr McCormick: No.

Mr McDevitt: Therefore, there are significant regulatory gaps, by definition.

Dr McCormick: The other way to look at it is that, where we are commissioning services from outside Northern Ireland, there has to be a guarantee of standards by another means. Yes; RQIA's remit is within Northern Ireland, but, if we were purchasing from across the water, the regulatory body would apply there. Earlier, you made a point about services secured from the South.

Mr Poots: Mullingar is an example. Perhaps John will explain how regulation operates there.

Mr Compton: In that situation, providers have to complete a procurement process, be successful and guarantee that they meet full professional standards, which we set. They have to show evidence of the work that they have previously done and provide the opportunity to meet whoever is doing that work. We reserve the right to attend any particular consultation or to contact individuals who have been to consultations to ascertain patient experiences. The personnel who are used must qualify as if they were employees of the NHS here in the North. There is a whole set of quite important issues around that.

Andrew covered the point that I suspect you were making, which is that regulation on domiciliary care will change. That is just a fact of life, so our RQIA will have more engagement in domiciliary care, and the Social Care Council will have more engagement in the registration of people who are delivering social care. That momentum is already in the system, and it will happen.

The word "privatise" is used a lot. The expectation here is quite clear that substantial amounts of services will still be directly delivered by the NHS. Large amounts of services will be provided by the voluntary sector and some by the private sector. That is a mixed economy, so to speak, but as I understand it, that does not represent anything different to the current policy position, which has been extant now for some considerable time. We expect to do that successfully into the future.

Mr Poots: Although £52 million is a lot of money, it accounts for just over 1% of the DHSSPS budget. It is not an indication of rampant privatisation of DHSSPS if it is 1% of what we do.

Mr Compton: To put that into context, if we are talking about the independent sector and the acute sector, it is 4% of the total amount of money that we spend on the acute sector, so we spend 96% in house. As the Minister pointed out, it is about 1% of the totality.

Mr McDevitt: Why would we not put a statutory ring fence around that to say that there is a sensible amount of the budget that should be available for flexibility, pressures, or whatever term is most appropriate? Why not find some statutory mechanism that spells out the core of the NHS, which we will protect in statute?

Mr Poots: We have a collective government here in Northern Ireland. We govern by consensus, so if I were to decide that I was going to privatise the health service, which I am not, I suspect that colleagues in the Executive would call those decisions in and say that that is not the will of the Northern Ireland Executive. We have safeguards in place. You do not need to legislate or create regulations for that type of thing, because we will operate flexibly within the system to try to address the issues that arise. If we hit a particular problem, be it in orthopaedics, cardiac services or ophthalmology, where we have to go out and acquire additional services, perhaps involving sending people to England or Dublin, that drives the waiting lists down. The important message is that, in virtually all areas, waiting lists have fallen quite dramatically. John probably has the figures at the tip of his tongue. I read through the figures again recently, and there is a very good success story to be told. Use of the private sector has helped to ensure that people do not wait as long to get services that they need very much.

Mr Compton: I will just make the point that the private sector has helped, but our own service has done a tremendous job as well. This year, we are approaching having 70% of all people seen within nine weeks. There has been a 30,000 drop in outpatients on the nine-week wait. This time last year, we had 7,000 people waiting for endoscopy. We expect that, by the end of this month, there will be, I think, only four people waiting for that service. There is a particular issue in paediatrics in that regard. That number might change between now and the end of the year, but it is a remarkable transition from where it was a year ago.

We should not be complacent about how we are performing. As you have heard me say before, I would not be complacent about that for one second. However, occasionally, when things are moving in the right direction, it is important to say so.

The Chairperson: We are doing a bit of work on that whole issue. We will come back to that specifically when we get some of the research.

Maeve and Roy are still to ask questions. I will not put you under pressure, but I ask you to keep the questions as concise and straight to the point as possible.

Ms Maeve McLaughlin: Minister, I noted that, yesterday, there was no discussion of, or reference to, the financing of TYC. I did note the reference to £13 million for mental health, £20 million for learning disabilities, £500,000 for carers' respite and £3·2 million for social care. Are those sums part of the £83 million figure that TYC laid out in relation to the shift from acute care to community care?

Mr Compton: On financing, there are two sets of figures around. There is money that is planned to be spent, which is currently in the system, and some of that is in the figures. There is also the money that is coming from the transitional funding. For example, all the integrated care partnership (ICP)

money is transitional funding. We have to bid for that transitional funding annually. In the year that we are just completing, we were successful with £19 million of transitional funding. We anticipate £28 million for the 2013-14 year, which will go into ICPs and other aspects of the transitional arrangements. We have yet to complete that debate. As part of the normal course of events, it will go through the Minister's office and the Department. However, I have no reason to believe that there should not be some degree of optimism about that money being available to us. We are planning on the basis of it being available, but time will tell.

We then have our normal budget arrangement, which was set four years ago. That arrangement indicated the amount of money that will come in annually. An amount of money will come in in 2013-14 year, and some of that is earmarked for some of the areas that were mentioned yesterday. So, if you like, it is a combination of two sets of moneys.

At the moment, we are moving from a position of having a traditional commissioning plan financial arrangement. We have TYC and transitional money. All of that is going into one thing, which is a total financial plan that puts it all together. We do not talk about TYC as separate from the delivery of ordinary commissioning services, and we do not talk about transitional funding as if it is somehow exclusive to the resources that we have in the totality of the system. I hope that that is reasonably straightforward.

Ms Maeve McLaughlin: There was reference previously to the breakdown of transitional funding over a three-year period. I think that the figures were £25 million, £25 million and £20 million. Is that in place?

Mr Compton: As I said, the £19 million came in the first year. That £19 million figure was related to what we could actually spend; it was not limited or cut. Remember that, when you do these things, you make a planning assumption about what you think that you could spend in year 1. In fact, £19 million was that figure. We think that we can spend £28 million during the incoming year. That is the figure that we will be talking about in the incoming year. The balance will come in year 3. That is how you get the £70 million.

Ms Maeve McLaughlin: How much of that has actually been used?

Mr Compton: In 2012-13, £19 million has been spent.

Ms Maeve McLaughlin: Has that been spent on the Transforming Your Care process?

Mr Compton: Yes. A lot of money has been spent on preparing for what ICPs will be involved in. By looking at database activity from general practice, we have got to know the names of patients and the numbers of people who are frail or elderly, or who have conditions such as diabetes. So, to give you an example, we are equipped and are placed to go to the delivery side.

Ms Maeve McLaughlin: Minister, one of the recommendations in the Committee's health inequalities report was that there should be an increase of 7%in the budget for early intervention. I think that that was based on figures that we looked at from the World Health Organization. Is that increase likely to happen? Is it realistic? What is your opinion?

Mr Poots: It would be a huge challenge to get to that level for prevention. We are certainly looking at that area, and we have driven up the budget each year and intend to continue to do that. So, although other areas have faced cuts, prevention has not.

TYC is about the whole aspect of early intervention. The integrated care partnerships will be a driving force for the delivery of early interventions. Prevention is obviously the ideal outcome. So, you engage in those discussions with the community. If you have fewer people smoking, you have fewer people with lung cancer and the other smoking-associated illnesses. If you have fewer people becoming obese, you will have fewer people with diabetes. So, it is much better to engage in prevention, and we will certainly continue to invest in that.

Ms Maeve McLaughlin: I have three points to make. I will bring them together, because I know that people are under pressure for time.

You referenced the equality and outcome framework in the previous discussion about cardiac care and GPs. Will you expand on that a bit? Central to TYC are the outcomes and how you measure them. We accept that measurement is not easy for health outcomes. Nonetheless, it is a key piece of work.

Secondly, your Department set up an infrastructure board on some of the capital investment that is required, particularly in the health and social care campuses. Will you give us a view on that? I think that there were some financial models to be looked at.

Thirdly, where residential care in the transition period is concerned, the issue has been raised that the alternative was not in place for the particular facility in my constituency. You know, Minister, that I have raised that issue and will continue to do so. It seems to be about the registration process, whereby RQIA rightly came in and examined the facility, which has evolved into something else over the years. It was effectively an out-wing of a hospital, but it has evolved into a place that patients stay. As a result, it has had to close. Has there been a review of that registration process? I ask because I am sure that other such facilities are in that kind of situation. The human cost of that is very apparent. I am wondering what work we have done in the interim to ensure that that does not happen or what we can do to mitigate that. The trust is in a position where it, obviously, cannot go against the RQIA and the regulations, but the facility has developed into something else through no fault of anybody who has been trying to provide a service over many years. So, I am interested in your thoughts on that.

Mr Poots: In everything that involves regulation, although you have to meet that regulation and it is there for a purpose, we must never fail to lose sight of the human dimension in the provision of healthcare. If we focus so exclusively on one thing that we lose the ability to take in the human dimension and deal with that appropriately, I think that we will be failing. So, that is something that we always have to keep at the top of our agenda.

Dr McCormick: I am aware of that issue. The trust raised it with us as a concern, and it is certainly an area that we need to look at to see what can be done to make sure that, as models of care evolve, the regulation system serves and facilitates them rather than identifies the kind of obstacle that you referred to. So, we are seeking a positive resolution to that.

Ms Maeve McLaughlin: What about the quality and outcomes framework and the infrastructure board?

Mr Poots: The infrastructure board has been making progress, and we hope to be in a position very soon to announce something in Lisburn and Newry. So, a considerable amount of work has been done on those primary care clinics, and they will oversee other areas.

You particularly wanted to know about the potential for an innovation hub in the north-west. C-TRIC's presence there obviously provides an opportunity to develop that further. We need to negotiate, particularly with the university, to ensure that we can drive quality and innovation. We have the memorandum of understanding with Invest NI, and we now have the task-and-finish group, which is very much looking at innovation and which has some really good people working on it, including the guy from New York. What is his name?

Dr McCormick: Dave Whitlinger.

Mr Poots: So, we have some really good quality people there, which will assist us in that.

Mr Beggs: You indicated the great importance under Transforming Your Care of the integrated care partnerships to shifting more services to the primary sector, in which GPs will play a major role. Our papers include a briefing note from the BMA that indicates its concern at 20 new clinical indicators for quality and outcomes framework (QOF), which I think can affect 20% to 30% of GP practices' incomes. It also mentions 23 QOF threshold increases and the removal of the minimum practice income guarantee (MPIG). The BMA note states that this will lead to the "destabilisation" of about half of GP practices. It also indicated that there has been a significant increase of 7% in the population of Northern Ireland over the past 10 years and that there has been no increase in GP funding for the past six years. Do you recognise that there is huge concern about the GPs' ability to deliver the service that you want under this model of change that you talk about?

We also got a letter from Dr Ian Buchanan, who has a practice in Carrickfergus and who I have spoken to. His practice is quite interesting, because he has bought in to modernisation and in to TYC

and integrated care partnerships. His practice has a GP minor injuries service and is doing GP specialist work. I would say that his practice is a fair model of what you want to move towards. I would describe Dr Buchanan as a level-headed professional, and I detected alarm and frustration from him about what he sees as barriers to delivering what he wants to. In his letter, he states:

> *"engagement in T.Y.C would be near impossible due to increased work pressures and decreased income."*

He highlights that the IT system that some of these indicators are meant to work with will not be in place for six months. He states that the removal of the minimum income guarantee is creating another financial risk to the practice, which makes him and his colleagues more adverse to risk and to change. He writes that the pressures to deliver it will require more admin and more space, which his practice does not have. So, he will not be able to hit these targets, and he therefore sees this as derailing him from where he wants to go and to where I think that you and your service want to go. How do we make sure that the changes and improvements are not derailed?

Mr Poots: A lot of what you said comes back to the QOFs, which can be useful in driving up quality and outcomes. However, I will ask Andrew to pick up on that point, because a lot of it is related to negotiations in which I am not directly involved. Nevertheless, I would encourage my people who are carrying out those negotiations to be tough, because we want to drive up the best standards.

I also indicated to them that I do not want burdensome standards imposed that do not actually improve things or targets that do not actually create real, tangible benefits and improvements. Andrew, can you elaborate on that, please?

Dr McCormick: Sure. The proposals in the Department's consultation letter from earlier this year set out some proposals for new and higher-standard indicators. So, the points that have been raised are valid. The ideas originate in evidence-based analysis of what should improve quality and outcomes. That is the intention. Many of the proposals are based on recommendations coming from the National Institute for Health and Clinical Excellence (NICE), and they have also been the subject of imposition or negotiation elsewhere in the UK as part of the four-country negotiations.

So, there is nothing bizarre or unusual in the proposals. Going back to what I said earlier, we need to be careful about unintended consequences. The intentions behind what is being proposed are good; the aim is to drive up quality, improve outcomes and secure more in primary care. However, the reason for consulting was to make sure that there is a chance to understand the consequences more fully. That is the stage that we are at now. The consultation closes in a day or two. We will listen to and consider the points that Dr Buchanan and many other correspondents made. There have been discussions with GPs in the past number of weeks to try to get to something that secures the real objectives of improving quality and outcomes and that avoids unintended consequences or issues that are not bearable. We need to look at implications for both workload and finance for the practices.

Plenty of evidence is coming through, and there is a very large mailbag for us as well as for you on this issue. We are very conscious of its importance, and it is a very live issue. The Minister will give us a remit for the scope, but we want to get to an acceptable outcome.

Mr Beggs: One of the unintended consequences that was mentioned to me in passing concerned diabetes and sugar levels. I cannot remember exactly, but there was a target for that of something like 90%. The person who said it to me was mentioned to me that he will not strive to hit that top target because he would have elderly ladies fainting if he did. So, there are unintended consequences in some of the ranges that are being stipulated, and I hope that that will be taken on board.

There was an ENT pilot in east Belfast that was deemed to be successful. It significantly reduced the waiting times for ENT from 45 weeks to four weeks. When will the formal assessment of that pilot be completed and a decision made to move on? That is another type of flagship, which, if working, needs to be rolled out without undue delay.

Mr Compton: The report is with the LCG, which will be considering it right now. My expectation is that, as long as that scheme is seen as sensible and I get the recommendation, it will be reinstated in not just that area. As I said before, we will be looking to develop that right across the Province in the 2013-14 year.

The Chairperson: Minister, Andrew and John, thanks very much. We probably could have talked all day about some of the issues on Transforming Your Care. I appreciate you giving us the update on paediatric cardiac care.

We are getting a number of letters, and there are some in the pack from GPs. Are members in agreement that, on the back of the information that we received today, we respond to those that we have?

Members indicated assent.

The Chairperson: I stress again, Minister, that it is important that we get to hear about anything that comes out of the Department before it becomes an issue. We have had a loving relationship; I do not want to fall out with you.

Mr Poots: I look to my officials to ensure that that is the case.

The Chairperson: OK. Thank you.