Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Transforming Your Care: Ministerial Briefing

3 July 2013

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Roy Beggs
Ms Paula Bradley
Mr Mickey Brady
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
Mr Eugene Rooney	Department of Health, Social Services and Public Safety
Mr John Compton	Health and Social Care Board

The Chairperson: The main attraction — sorry, the Minister — is here. You are the main attraction. It is our fault this time, Minister. We got our business done earlier than we thought we would.

Mr Edwin Poots (The Minister of Health, Social Services and Public Safety): There are a lot of people here today. There must be something on.

The Chairperson: They heard that a pop group called TYC was here. *[Laughter.]* I will hand straight over to you. You are more than welcome. If you would like to make your presentation, we will then go straight into questions.

Mr Poots: Thanks for the invitation to come to the Committee. As you know, I made a short statement to the Assembly, so I can always flesh that out and take a bit more time than I took then, but I might avoid doing that. I welcome the opportunity to meet the Committee today to discuss Transforming Your Care (TYC). This will be more of a question-and-answer session. My statement set out the progress on taking forward the transformation of health and social care across a wide range of areas, including TYC and the work that is being undertaken on the shift towards greater provision of care closer to home.

I reiterate my key underlying point: no change is not an option. We face a range of immediate and long-term challenges, including the economic context, the growth in chronic conditions and the over-reliance on hospital beds, and that means that change is essential. Ninety-seven per cent of those who responded to the 'Transforming Your Care: Vision to Action' questionnaire highlighted their

support for the need to change. Of course, that does not mean that people do not have concerns about what the changes will mean for them and their families. We are committed to making sure that communication and discussion are at the heart of our work.

With that in mind, it would be helpful to pick up on a couple of key points at the outset, the first of which is the reconfiguration of acute services. In a statement last week, I highlighted the fact that the 'Transforming Your Care: Vision to Action' consultation set out a potential reduction of 180 beds in secondary care across Northern Ireland. The planned shift of services through TYC is expected to facilitate a progressive reduction in need for acute inpatient beds, and that change relates to the three years starting from 2014. Equally but separately, the ongoing action by trusts to improve their efficiency through, for example, reduced lengths of stay will also see some reduction in the need for acute beds over a three-year period. We will have to take that into account, but I have made it very clear that it can only be done without compromising the quality of acute services or access times for elective or unscheduled care. Those changes will help to ensure that our health and care services are working as effectively as possible for our service users and patients.

Earlier this week, my Executive colleague Sammy Wilson announced that we have successfully secured a significant allocation of £54·6 million via the June monitoring round. Those moneys will play a pivotal role in enabling my Department to deal with a range of important projects. The funding will be used to benefit a large number of patients and service users across Northern Ireland, and, within that overall allocation, we secured £9·4 million towards the transitional costs of TYC. Those moneys will be used to help to sustain the work that began in 2012-13 and will enable additional service transformation to commence in 2013-14. Although those moneys will make a substantial contribution to the implementation of TYC, it will be important that we also continue work to identify opportunities to secure additional moneys such as, for example, in the October monitoring round to maintain momentum across the entire TYC implementation programme.

The Committee received a short briefing paper on TYC implementation in advance of today's session. It summarises a number of areas, including resettlement, reablement and residential care, which I covered in more detail in my statement. I understand that the Committee also received a revised draft of the strategic implementation plan for its evidence session on 19 June and details of the changes made to the document in response to the consultation. I am happy to take questions, Chair.

The Chairperson: Minister, thanks very much. I will go straight into it. In the June monitoring round, you bid for £28 million to implement TYC, and you received only £9·4 million. How will the Department meet the shortfall in funding to ensure that TYC continues to progress?

Mr Poots: As I said, we will go back in October to look for more moneys. We have made the decision that we will progress with the £9·4 million at full speed. There has been a fairly significant reduction, I believe, in the overspend, and, consequently, we believe that moneys will become available in later monitoring rounds. So there is an element of calculated risk that more funding will be available in monitoring rounds later in the year and that there will be greater levels of funding than there perhaps were last year.

The Chairperson: You said that you will go back in October but that everything is going at full speed. As the bid was for £28 million, I am sure that you did not get all that you asked for in this monitoring round. What will happen between June and October?

Mr Poots: Initially, we were looking for £75 million for Transforming Your Care, and we have already received a number of bids. John, perhaps you can identify what we have received thus far and what will be required for us to finish that process.

Mr John Compton (Health and Social Care Board): To answer the question specifically, the £29 million was a full-year spend. The spend profile runs out on a monthly basis. About 50% of the spend profile was for voluntary redundancies (VR) and voluntary early redundancies (VER). That would not come into play until the last quarter of the year, so that would cut the £29 million by about 50% to £14 million or £14·5 million. We are proceeding on the basis of the £9·5 million, and then it depends on what happens in the October monitoring round. We could probably be in a very difficult position in the late autumn, when a difficult set of choices would have to be made. The current spend profile will allow us to continue to work with TYC. We will be spending the money, principally on enabling the changes to take place and supporting those changes, the integrated care partnerships (ICPs) and service redevelopment. In any event, we would not have been using the VR or VER resources until the very end of the year. That is the normal course, because that would be the product of having

made the change. Things would have to be done on how the workforce is handled, which would be done after the changes unfold as opposed to ahead of the changes.

The Chairperson: I will come back to the integrated care partnerships in a minute. I have always given TYC a guarded welcome; it is about how it works in reality on the ground. When dealing with and challenging early intervention and prevention, I agree that that involves a lot of movement from the acute sector into the community. The Committee has done a lot of work on health inequalities. We produced a report, and you responded on our recommendations. We will come back to that in more detail. Can you explain how you envisage TYC specifically addressing health inequalities?

Mr Poots: There is a significant section in TYC on public health, because we view it as an absolutely critical factor. We are trying to reduce the amount of time that people spend in hospital by using different practices, earlier interventions, and so forth, and practices outside the hospital environment. The best way to reduce people's need for hospital is by dealing with public health issues so that they do not require care. That is why we are strongly disposed towards more investment in public health. Health inequalities are wholly evident to us, which is why we want to target areas in which health inequalities exist. In other areas of the Department, in conjunction with the Office of the First Minister and deputy First Minister (OFMDFM), we are undertaking work on parenting and early years so that we can have a whole-life approach to healthcare, thus ensuring that children get the best possible start in life and that outcomes throughout life consequently improve.

John, do you want to elaborate on any of the issues arising from TYC?

Mr Compton: The 5% shift of money away from hospitals is clearly earmarked and targeted to go into the difficult areas in which there are health inequalities. About 50% is earmarked for community care services, 25% for services such as family and childcare, and 25% for primary healthcare services. That resource is to enable health inequalities to be addressed. The commissioning specifications are about end-to-end commissioning. Take diabetes, for instance. It is about trying to prevent people from becoming diabetic by commissioning in a different way and by working with communities in a different way. When there is an issue with diabetes, it is about managing any escalating problems so that people are kept as fit and well as possible. In the end, that is how health inequalities will be reduced.

We believe that we can do that. You only have to look at the amount that we spend on our hospitals on chronic diseases, and the number of people being admitted to hospital with chronic diseases. If you change the pattern of how that service is provided, you can reduce it. That would give us some confidence that we are going in the right direction and can shift that resource to achieve that outcome.

The Chairperson: Buy-in is required from the community and from individuals. I have submitted questions to you, Minister, about integrated care partnerships. How will the community sector be represented on the ICPs? Will it specifically be community sector organisations rather than big voluntary organisations?

Mr Compton: Yes. We recognise that there is a voluntary sector and a community sector. That has been made quite clear to us. Each of the 17 geographies in which there will be ICPs will have a slightly different approach. In the Belfast arrangement, for example, there has been a strong lobby on community engagement. My colleague Dr Sloan Harper has agreed to have community representatives on the care networks, which are not organisations as such.

We are beginning to identify who wants to be there, and we do not object to anybody. We view that as coming from the community, and it is not for us to prohibit an individual being part of an integrated care partnership. However, those people will be there for a reason and a value so that they can drive the management of the issues that we have spoken about previously in Committee: services for the frail and elderly, respiratory services, diabetes services, stroke services and the end-of-life-care arrangements associated with those conditions. That is the first area that we are focusing on, because it has to be done in bite-size chunks to make it real. We cannot do everything at once.

The Chairperson: TYC has taken a battering lately. You have taken a battering, Minister, as have you, John, probably justifiably.

Mr Poots: Not for the first time.

The Chairperson: Do you have any plans to resell Transforming Your Care to the community? A sizeable percentage of people did not know what Transforming Your Care was, and now all they hear about is negativity. Do you have a strategy for reselling it?

Mr Poots: Irrespective of who sits in this chair in the future, regardless of their political party, he or she will follow a template that is not very far from the one that I am following. There is no alternative to TYC. We have increasing numbers of people with chronic illness, an ageing population and financial constraints for the foreseeable future. Even if a Government is spending more money, there will be a significant challenge to get more money into health because of the way in which rating agencies look at government finances and how that would affect a Government's status. I do not see someone else doing things hugely differently to the way that we are doing them now.

The Chairperson: I am talking about selling the TYC product so that when people hear TYC, they do not panic.

Mr Poots: I recognise that we took a fairly significant hit over the residential homes, and there is the potential for that to happen with other issues. The press and media love negative stories. Journalists will tell you that if a plane lands safely, nobody is interested, but if a plane crashes, everybody wants to know. That is the media's world view, and they like to tell bad stories. So if we do lots of good things, people may not know about them, but they will feel their effects.

I have to get out there, as do other people on the team, to market TYC to the public and explain the reasons for it, which I identified a moment or two ago. We do not want to reduce care; we want to change the model of care. We do not want to do away with the National Health Service (NHS); we want to ensure that we have a National Health Service that is sustainable into the future. If we do not do certain things, there will be a serious detrimental impact; for example, we would be spending money on tackling waiting lists, which means going into the private sector. However, if we do not spend, waiting lists will ultimately grow and more people will go private. So we are using public moneys to ensure that people get that service. If we did not do that, people would end up having to pay for a service themselves, which is not where we want to be. We want to provide a health service to the public that is free at the point of need for everyone. I suppose that we keep hammering the message out and doing as much as we can to get those messages across.

The Chairperson: We will deal with cancelled appointments rather than waiting lists, because it is an issue. We will come up with some suggestions for you when we come back. Research is being done on that.

Ms Maeve McLaughlin: Is an outcomes framework attached to TYC to date?

Mr Poots: We have set ourselves targets and objectives, and it is important that we deliver against those. As TYC is rolled out, we constantly look at targets that we have set for ourselves. We set out to establish integrated care partnerships, and we had wanted them to happen earlier than what we have achieved. However, integrated care partnerships are now up and running across the regions before they become fully operational in the 17 areas. We have our targets, and we look at how we are meeting them.

Ms Maeve McLaughlin: Is there a specific reference point, through a document or documents, that tells us that shifting £83 million from acute care to primary or community care will have a range of outcomes?

Mr Compton: Yes. The Minister mentioned the 180-bed reduction. In 2014-15, we expect some 70-plus beds to come out of the acute hospital system, and that is to do with the change in investment and the management of chronic disease. We have undertaken some extensive work across the population on the people with chronic disease who are most likely to use our hospitals so that we can target effort and energy into ensuring that they do not end up in hospital. We have set ourselves a target date of 2015 for the resettlement programme for people with learning disability and mental health issues. We have set a target date for the full implementation of family hubs across Northern Ireland through the three-year period. We are beginning to deliver and implement a whole range of individual programmes. This is the "implementing year", and the controversy is about the handling of change. We are trying to change the service and, at the same time, running the existing service, which is why transitional funding is important. We are not taking things down until we do things in their stead.

Ms Maeve McLaughlin: With respect, it is about handling change. That is critical. It is also about being able to stand over and justify the outcomes of that change. So if you are saying that there is a document on the series of services in TYC and their outcomes, it would be worthwhile for you to share that with the Committee.

Mr Compton: We can get you those sorts of things.

Ms Maeve McLaughlin: It is my understanding that the project initiation document on statutory residential care has been submitted to the Department. It contains the terms of reference. It would be appropriate for the Committee to have sight of that.

Mr Poots: OK.

Ms Maeve McLaughlin: My question is on the strategic implementation plan, which is included in your briefing paper. John, I raised this issue with you previously, and I still have not been given a proper or justified explanation. A draft strategic implementation plan was submitted to the Department in June last year, yet the consultation did not start until October. If we are consulting on a set of core principles on the biggest shift in the health service that we have ever seen, I do not understand how a draft implementation plan can be with your Department a number of months before the consultation goes out.

Mr Poots: It is a draft plan as opposed to an implementation plan, so it is a working document that needs to be revised. We would not have put that out in July or August before the Assembly came back, which is usually the second week in September. If we had done so, we would inevitably have been criticised for trying to circumvent the Assembly and, indeed, the Committee in some way.

Ms Maeve McLaughlin: If the consultation on Transforming Your Care and a shift from acute care to community or primary care had been rejected, there was an implementation plan in the Department that was based on those principles, yet it had not been consulted on. That is a critical point to do with impact.

Mr Eugene Rooney (Department of Health, Social Services and Public Safety): The document was presented in draft to the Department at the end of June and was published. At that time, the Minister made a statement to the Assembly on the presentation of the draft implementation plan and the population plans. They were then subject to quality assurance work over the summer, and, at the same time, they were available for others to comment on publicly. Therefore, the documents were available publicly, the quality assurance work was completed, and the document formed part of the consultation exercise that was launched in October. After quality assurance, the draft was available for public consultation when the 'Transforming Your Care: Vision to Action' document was launched on 9 October.

Ms Maeve McLaughlin: I am sorry; the document that I read stated "a period of further consideration", which is something very different.

I listened carefully to what you said about changing the patterns around the provision of health and trying to reduce hospital numbers and all that goes with that. Minister, I have submitted a question for written answer on self-referral, and the commissioning plan refers to a pilot on self-referral. We looked at evidence from Scotland and England and have been told how those processes can work, not only for health outcomes but for economic benefits. Why are we being told that there may be a pilot in one trust? Surely if we know that something is working as best practice, why can it not be more than just a pilot in one trust? Can we not be a wee bit more ambitious?

Mr Poots: We normally undertake a pilot in a single trust because it is not just about how it works for patients. It is also about its outworking and how the workforce responds. There is a series of issues. It is regarded as good practice to have a test period so that as it is rolled out across Northern Ireland, we can implement it in a way that benefits the entire population as opposed to going for the Big Bang process. We like to do things incrementally.

Ms Maeve McLaughlin: Of course, we need to recognise our own set of circumstances. However, I would suggest that if the model has worked and there are examples of best practice elsewhere, we should examine those and think outside the box about the potential of implementing this.

Mr Poots: We certainly learn from others and look at best practice, and, on occasions, others look at best practice in Northern Ireland. We hope we are helpful to others and share qualitative information across the regions. We have a close working relationship with Scotland on sharing information, which is advantageous to all of us.

The Chairperson: You will be glad to know, Minister, that we agreed earlier to write to you about the number of pilot projects that the Department has been involved in over the past five years. We will await that information.

Eugene, what is the assurance work?

Mr Rooney: Essentially, the board presented the draft implementation plan and the population plans at the end of June last year, the Minister then made a statement, and they were made available publicly. During the summer, we worked with the board on the detail of the documents and agreed changes so that they were available as a revised draft at the time that the formal consultation on 'Transforming Your Care: Vision to Action' was launched on 9 October. The latest draft versions of the strategic implementation plan and the population plans were published at the same time.

The Chairperson: Is it quality or equality assurance?

Mr Rooney: Quality assurance: checking facts and figures through the documents and making sure that they align.

The Chairperson: I thought that you said equality and that it was another way of getting out of your equality impact assessment. That was my fault. I thought that I had you there.

Mr Poots: No reds under the beds this time.

Mr Rooney: The consultation document covered equality issues as well.

Mr McCarthy: I support what the Chair said about Transforming Your Care and the public not knowing that it is happening. As recently as yesterday, we had a meeting in the Long Gallery, and it was full. When the people there were asked whether they knew about Transforming Your Care, the number who did not know about it was unbelievable. The Minister has acknowledged that, despite, I think, every home in the country being sent a leaflet, that is the case.

Mr Poots: Yes, they were.

Mr McCarthy: They still did not know about it. Anyway, here we are.

You say that domiciliary care will be at the heart of the transformation. When I talk about domiciliary care, I mean not only elderly people but people with disabilities, learning difficulties and so on. Already, carers are under extreme pressure and home care visits are being reduced, and we are only starting on this journey. The meals-on-wheels service is under extreme pressure. In fact, in the 'News Letter' this morning, there was a story about a 90-year-old lady up the country who has been informed by letter that she will no longer receive meals on wheels. Can the Minister assure the community and provide us with confidence that there will be sufficient domiciliary funding to all those community-based services to enable people to live in their own home — that is what Transforming Your Care is about — in comfort, in a way that preserves decency and dignity and with food on the table?

Mr Poots: All of what Mr McCarthy says is perfectly reasonable. Transforming Your Care cannot work without investment in domiciliary care. We must ensure that we provide that support to people. There is no point saying that we will try to keep people at home, but, as people's conditions deteriorate, not responding. It is critical that we respond to people's needs, and, very often, that will be not be done by cutting the hours of care provided; it will mean increasing them.

It is very important that the trusts respond very positively to ensure that people are supported in their home. There needs to be, for example, reasonable payment for meals on wheels because food inflation and fuel inflation have been high, so the providers of those services need to get more money than they currently do. I am looking at raising the money paid for meals on wheels.

We also need to look very carefully at elderly care, especially the needs of the frail elderly. It cannot be one size fits all. Somebody may call in for 15 or 20 minutes or less and are out the door, but we need to ensure that, if someone requires 30 minutes' care and support, they get it. I accept that we need a bit more flexibility built into the system. If TYC is to work, we need domiciliary care that is considerably more flexible than it is now, and it will almost certainly mean a greater investment.

Mr McCarthy: Chair, I am glad to hear that commitment by the Minister.

Minister, can you give an assurance that there is a fallback position as we travel on this journey? Transforming Your Care is only in its infancy. If we reach a situation in which these people are not receiving that care and support, is there a fallback position to keep them out of hospital? We want to ensure that they remain at home and are properly looked after without having to go into hospital, which would defeat the purpose of TYC.

Mr Poots: In truth, the fallback position has always been that people ended up in residential care. We have made it very clear that that is not what we want for people, but that will still exist. Very often, people who do not get the support that they need to stay in their home go into residential care. We wish to avoid that, but, realistically, many people will still require residential care, irrespective of the support that we can provide for them at home, because they simply become too frail. Nonetheless, we can do an awful lot better, and, to do better, we need a system that is flexible in its response to the needs of the community. The community cannot be flexible according to the needs of the system; it needs to be the other way round. We need to respond to public needs.

Mr McCarthy: John, the document mentions the reduction of 180 beds in the years ahead. Again, that is very concerning because we know that, in all of our hospitals, there are already waiting lists and patients lying on trolleys. Yet you propose to cut 180 beds. Is that justified and correct in the times that we are in?

Mr Compton: I think so. If you look at the efficiency measures — how hospitals perform and who goes into hospital — and at comparative information on the Northern Ireland hospital block and how it performs against the rest of the UK, you will see that there is clearly scope for it to be more efficient. Part of that is ensuring that only the people who absolutely require hospital care go to hospital. We have numbers of people who can be managed outside hospital, so I think that it is entirely possible. After we invest in 2013-14, only the first tranche of beds associated with TYC will come out in 2014-15. It is about putting money in before taking beds out. That does not stop the continual drive for efficiency, which may take beds out in any event, but it is important that we are doing it in that way.

I am on record as saying to you that we are investing a further £9·5 million, or just under, in domiciliary care this year. The number receiving domiciliary care has grown by over 500, and the average length of time that each person receives such care has grown from about nine and a half hours to about 10 and a half hours. I know that, when I talk about averages, it does not tell you about individual circumstances. We are mindful of the figures and of situations in which it appears not to work in individual circumstances. Part of what Transforming Your Care is about is trying to move away from the one-size-fits-all approach. In the midst of all this, the biggest difficulty lies in trying to force everyone into a one-size-fits-all response. At the heart of Transforming Your Care is the flexibility to give people greater choice, greater control and greater say over what happens in their, on average, 10 and a half hours of care.

Mr McCarthy: I hear what you say about hospital beds. When last here, you informed us of further investment in the Ulster Hospital to create 20 extra beds to cope with the volume, and I was grateful for that. Today, you create 20 extra beds in the Ulster, but you pull 180 from elsewhere in the system.

Mr Compton: That is all to do with the assessment of need. Often, our hospital system is an accident of history more than a design for assessed need. We know the volumes going into a hospital and we do demand-capacity work, so we know what the demand for a particular facility is and its capacity. As a commissioning organisation, we have to buy in a way that balances the demand with the capacity. It is not the same everywhere, so it is important that we are always mindful of that. We cannot ask a given hospital to do something that is simply not doable.

Mr Brady: Thanks for the presentation. I will be parochial by mentioning Newry, but I will also mention Lisburn, so you can also be parochial if you want, Minister. You made a ministerial decision on the health and care centres and integrated care partnerships in Lisburn. Did you take into account the

advice? In an earlier meeting, your permanent secretary seemed to indicate that, irrespective of recommendations, you made a ministerial decision. Maybe you will clarify that.

Mr Poots: Yes, and I have since made other ministerial decisions because, if we wanted civil servants to run the country, there would be no point in having elections; direct rule Ministers could just come in and sign things off. When Ministers see a need, they will deliver on it. One of the things that we looked at in Transforming Your Care was a bespoke model, in which we had all of the facilities that were available and could provide a wider range of services to the public than is currently the case.

Fortunately for Lisburn and Newry, they were two of the areas identified as having a high need for such facilities. As two of our larger conurbations, they were deemed suitable for pilot projects, which take us away from what we have done in Portadown, for example, and in Ballymena, Banbridge and half a dozen facilities around Belfast. However, there is a huge demand for more such facilities. Mr Gardiner is looking for one in Lurgan; Mr Dunne is looking for one in Bangor; and Mr Beggs is looking for one in Larne and Carrickfergus.

Mr Gardiner: Minister, am I right in saying that you have granted the facility in Lurgan?

Mr Poots: Not quite yet, no.

The Chairperson: We will stay away from the parochialism, but Twinbrook will do me.

Mr Poots: The truth is that, if we are to roll out TYC successfully, we need to get such facilities in place. We cannot wait for a new round of funding from Westminster because the time waiting would be time lost, and it was on that basis that we made the decision. I should say that, currently, 70% of our health centres are privately owned by GPs. In fact, the leader of Mr McDevitt's party, I believe, is one who owns his GP premises.

Mr McDevitt: I do not believe that he is a GP any more, but that is a matter of record. You may want to correct that, Minister.

Mr Poots: That is what has been done in the past.

Mr McDevitt: You might want to rephrase that.

Mr Poots: There certainly has been a lot of private sector involvement in the delivery of primary care services. In fact, the GPs are independent contractors. I can assure Mr Brady that it is not a case of us seeking to privatise the health service by stealth. When it comes to capital funding, we have to be a bit more creative and innovative in our thinking about how we ensure that progress is not stilted by a funding round falling well short of expectations. Remember, we lost over £1 billion of funding in that capital round.

Mr Brady: On that point, last week, I met local GPs, who had met Sloan Harper recently. There is still some uncertainty because the health centre in Newry is less than 20 years old. It was opened in 1995. The trust needs premises, so there is an ongoing issue of co-location versus a split site. The GPs are not saying that they are averse to a health and care centre, but they are saying that they need certainty, and that has not happened. I brought this up before, but that uncertainty still seems to be there.

An evaluation of an integrated care pilot in the North West London Trust found little evidence of an impact on emergency admissions. I know that Ling et al have evaluated other integrated care pilots. Of course, for the London pilot, it is early days because the evaluation was of its first year. Transforming Your Care may be displaying what could be termed "optimism bias" in expecting much of a reduction in emergency admissions. If so, budgetary plans and plans to close hospital beds would be flawed. Will you comment on that?

Mr Poots: In all such matters, we look at what takes place elsewhere. We look at what has the potential to work, pick up on best practice and demonstrate leadership where we believe that opportunities exist. I believe that others will pick up best practice in Northern Ireland as time goes on. In fact, many proposals in England appear to follow what we are doing now. Over time, we will see how this pans out. We have not entered into this blindly. John worked with a team of people with a fair degree of expertise — Chris Ham from the King's Fund, Ian Rutter and so forth — to pull the report

together. I believe that it was a well-thought-out report. It identified potential ways to deal with chronic illness and frailty, which are the two biggest pressures as we look ahead.

The pressures will not come from open heart surgery because we can deal with that. We will have more cancer, but we have installed linear accelerators and have the oncologists and so forth to enable us to deal with that. Looking to the future, if we keep doing the same thing, we will not be able to deal with the frail elderly, people with diabetes and people with respiratory illnesses. The pressure comes not from the highly technical conditions but the sheer deluge of work that comes from the simpler ones. If we continued doing the same thing, that deluge of work would make it unsustainable. That is why we chose to go down the route that we did.

Mr Brady: If emergency admissions do not significantly reduce but hospital beds have been closed, how will that gel? If it is recognised that this does not work, will there be flexibility to reopen hospital beds?

Mr Poots: One area that we are looking at is hospital at home, and I recently witnessed examples of that. Everyone engaged in the process is happy with it: for example, we visited a woman with a respiratory illness whose condition had deteriorated. Normally, she would have required hospital admission, but she was able to have the IV drugs administered at home. That was positive for the hospital and viewed very positively by her. The nurses can go beyond giving IV drugs; they can do blood transfusions and so forth in people's home. There is work that can be done in the home that would otherwise be done in hospitals. John wants to come in on this as well.

Mr Compton: Yes, I was going to make the point that one follows the other. That is why the investment is happening this year and the beds will not start to come out until the second half of next year. Clearly, you have to show that it is working. There is confusing evidence about the North West London Trust. I have seen other evidence of a 6% to 7% reduction in emergency admissions. A comparison of the core general practices involved with the trust and the core general practices adjacent to that area, shows a 6% to 7% reduction.

We also know that, because of how we handle some chronic diseases, particularly cardiac diseases, there is a reduction in hospital admissions in any event. This is about galvanising that in a more organised and co-ordinated way. Clearly, one follows the other. That is the whole purpose of implementing change and signalling that the reduction in beds will come later. There is always a danger of confusing our drive for efficiency, which is also to do with beds, with a change in patterns of behaviour, which is TYC. The money will go in this year, and the working assumption is that about 70 beds will come out in the second half of 2014-15. So there will be a full 15 to 18 months after investment before the beds come out as part of the TYC process.

Mr Brady: There are, of course, subjective and objective interpretations of reports.

Mr Compton: Of course. There is no point in trying to run a system in which you ask a hospital sector to do things that it simply cannot do. The Minister is correct: the single biggest issue for us is how to deal with the chronic illness that is a consequence of an ageing population. In providing modern health and social care to that group, the volume, scale and number represent the biggest challenge, not only for our society but for most of the western European societies

Ms P Bradley: In your briefing paper is a sentence on reablement:

> *"Work is ongoing between the HSCB and Trusts to develop their business cases".*

It continues:

> *"This includes an examination of current service models for older people and a range of options for a proposed re-ablement model."*

We have spoken about reablement in Committee many times. I have said before that, when I worked for the Northern Trust, we used reablement, which came into effect there about three and a half years ago. Why are they developing business cases for a proposed reablement model when we have already been using it? We know from the chief executives of the other trusts — not just the Northern Trust — that all trusts use the reablement model. Why develop a model and business case now? Surely that would have been done beforehand.

Mr Poots: We recognise that reablement has been going on for a long time. We think that we need more of it and need to do it better. In the business case, we will examine the current service models for older people and, indeed, a range of options for a new model through which we can deliver more reablement. Significant time was spent establishing baseline activity for all the trusts so that we can monitor our future performance. You are absolutely right that we have being doing reablement, but we need to do more of it, and we are engaged in work on that.

Ms P Bradley: Thank you. Has there been a review of how reablement has worked to date, how successful it has been in each trust and the patient/clients for whom it has been successful or otherwise? It is not always successful and does not always work, so it is not a panacea. However, when reablement works, it is good.

Mr Compton: The answer is yes.

I will go just go back to your point about the business case. Maybe the language is confusing. It is about additional services. When we commission new services from an organisation, there is a process whereby they tell us what they want to do and how much it will cost, and that is the business case. So this is not about redoing the entire reablement model; it is about additionality.

We are doing a mapping exercise to assess the need. Using the children's model that we used previously, we will be able to map every service in every geography in Northern Ireland. That will help us to assess where we need to invest money and the types of services that we need to invest in. Where reablement does not work and there is a problem — you are right about it not being one size fits all — we will look at why it did not work, what the issues, problems and difficulties were, and what we should do slightly differently.

Again, we expect some of the business case information that comes through to reflect some of those difficulties and indicate that, if they want to provide a different service, they will do so in a slightly different way to avoid some of them.

Ms P Bradley: Is the mapping and what is going on now looking at all services across the board for older people?

Mr Compton: The whole service.

Ms P Bradley: In every trust?

Mr Compton: In every trust. It is looking at the whole of Northern Ireland. As I say, in each geography, it is trying to map the geographical location of the voluntary, community and statutory services against the population maps.

Ms P Bradley: There are major disparities. When I worked in Whiteabbey Hospital, which, as you know, is on the periphery of the Northern Trust, we had patients from the Belfast area as well as Newtownabbey. If we got a Belfast patient/client, it was good because services were available there, which meant that we could get that patient out of hospital more quickly and better plan their discharge. So reablement needs to be right across the board for a range of services.

Mr Compton: It does, and this is all to enable the local commissioning organisations to have a much more assertive ability to commission those services locally for their populations.

Mr Poots: Reablement is a critical element of what we are doing. There is a debate on residential care, for example, and reablement will ensure that people do not end up in residential care. Historically, when something went wrong in people's lives, they ended up in a care situation, and, very often, that went on for over 10 years. People should not need to be in care for such a long period. Reablement will give us the opportunity to work with individuals while they are receiving getting intermediate care to help them to get back on their feet and do normal things again.

The Chairperson: You touched on residential care. I take it that some of these policies or strategies will have a regional approach. Paula mentioned that when staff at Whiteabbey got a patient from Belfast, they were happy. For reablement to work, the services need to be delivered equally across

the board and not depend on where people live. That is key, and that is where the trusts play their part. There needs to be a regional approach to all of this.

Mr Poots: John mentioned the commissioning organisations as opposed to the trusts, and that is an important element of it. John will perhaps elaborate a little on that.

Mr Compton: We are trying to establish, in very simple layman's terms, an 80:20 rule: 80% of the framework of care in Northern Ireland should not be address dependent; it should be the same wherever you live. There will always be the need to take account of local factors: the 20%. These are opportunities to do something in a geography that simply does not exist somewhere else. If, for example, a very strong parent group on learning disability runs a service in one area, you cannot compel parents in another area to do the same. Neither would you want to diminish that service, so we are establishing that 80:20 principle. That runs all the way through the ICPs and through the framework document for elderly persons' homes, so there will be regional co-ordination.

The Chairperson: I appreciate that, John. However, I am trying to warn you that we need to have this overview. It is similar to the meals-on-wheels service. Minister, when you sent out a ministerial direction to trusts on that, three of them chose to ignore you.

Mr Poots: Yes.

The Chairperson: We need to make sure that this does not depend on where people live and that we do not go down the road of a postcode lottery again. You need to be hard and ensure that the 80:20 principle is delivered.

Mr Poots: The principle very clearly addresses the issues that Paula raised.

Ms P Bradley: When we look at services, we are looking not just at assistance with activities in daily living but at the social aspect. I know from personal experience that a large number of people go into residential care for purely social reasons and not care reasons. The range of care services available must be broadened to make this successful. To keep people out of hospital and residential accommodation, we need more basic services that are not all to do with activities of daily living. It needs to be more than that.

Mr Poots: We cannot ignore elderly isolation. Keeping people in their home is not ideal if they never see anyone. Although people want to stay in their own home, importantly, they also want to engage and communicate with others and have a bit of vitality in their life.

Mr McDevitt: I declare an interest as a parent of a child with type 1 diabetes. This is my rant, John, and it is quite a serious one. On six occasions today, when talking about diabetes generally, you said that it was preventable. Diabetes is not always preventable.

Mr Compton: No, of course it is not.

Mr McDevitt: Indeed, very many children have type 1 diabetes through no fault of their own. What grown-ups, particularly grown-ups in positions of great authority and power like you, say leads to their getting bullied in school. Their friends tell them that they are fat, have eaten too many sweets and, therefore, have diabetes. I ask that, when we talk about a diabetes epidemic, we, please, talk about what it is, which is a type 2 diabetes epidemic, and that we always say that. You do not want a child to come home and ask, "Why am I bullied for a having a condition that I did nothing to get, that I will never be able to cure and that I have to live with?"

Mr Compton: There is no intention to do that.

Mr McDevitt: I wanted to say that, and I am sorry to have had to bring it up.

The Chairperson: You were right to raise it. Let me give John the opportunity to clarify this.

Mr Compton: I agree with you. What you said is 100% correct. I was not using the word in that sense. I was using it, at that point, to talk about the debate on health inequalities. I am completely aware of the variety of forms of diabetes. Some are preventable because they may be attributable to

lifestyle, but others are clearly not. The important issues are education — the ability to self-manage needs to be taught from an early age — and for people to be supported to enable them to self-manage in such a way that their life is not disabled as a consequence of the illness.

Mr McDevitt: Thank you, John.

Minister, what other ministerial directions have you issued since the one on Newry and Lisburn?

Mr Poots: I am looking at others and will probably make a decision tomorrow.

Mr McDevitt: Do you want to tell us about those?

Mr Poots: I want to make a decision. I will give you the information tomorrow.

Mr McDevitt: May I ask you about those? Are they ministerial directions that will involve overriding business cases for the commissioning or construction of new centres?

Mr Poots: They will involve financial decisions, yes.

Mr McDevitt: So, by definition, they will all require the overriding of business cases.

Mr Poots: It is not the overriding of a business case. Business cases are presented with various models. You may have the model that demonstrates best value in the instance of health and care centres, but best value is really what you deliver on the ground. If you do not deliver it, you do not deliver best value.

Mr McDevitt: I may have picked you up wrongly in the House the other day. In response to my question, did you say that the Newry and Lisburn centres would be cheaper to build had you followed the business case instead of issuing a ministerial direction to have them built privately?

Mr Poots: Had I the money in the system, we could do it cheaper ourselves; yes.

Mr McDevitt: So, you have issued an instruction to spend more money, and your rationale is that that will get it done quicker.

Mr Poots: Yes; and, consequently, we will save money.

Mr McDevitt: OK; but it will cost more to do it that way.

Mr Poots: It will cost more from a capital perspective. However, the consequence is that we will be able to do more for people at primary care level, avoid hospital admissions and ensure that TYC rolls out. There is a considerable benefit to not waiting until the next Westminster spending round.

Mr McDevitt: Are you telling me that the Minister of Finance would not be interested in hearing a bid from you for a business case to do it through the traditional procurement method — i.e. to do it in the public sector — as was suggested in the business case that was put in front of you? Are you suggesting that he would not be interested in hearing such a bid as an invest to save?

Mr Poots: That would involve moving moneys from already committed resources, because all the capital infrastructure is already committed. Money came back from the A5 project, and we bid for that. Quite a number of political parties thought that all that money should go to roads. I cannot recall the vote. I am not sure whether or not the SDLP was one of the parties that wanted to commit that money exclusively to roads.

Mr McDevitt: Let us just deal with this issue. This is the Health Committee.

Mr Poots: That money came forward, and we made bids for it. However, there is no way that we were going to be successful with bids for £80 million.

Mr McDevitt: OK. We are spending more to do it privately, but we will get it quicker. You will be issuing another two directions tomorrow. As they are directions, I presume that we will have to spend more. Will we get them quicker?

Mr Poots: They are not for HSC facilities. They are for primary care facilities.

Mr McDevitt: So, that is different.

Mr Poots: It is different. Ministerial directions happen. That is where we have more clout to deliver on these issues than the accounting officer.

Mr McDevitt: I want to pick up something that you said earlier about waiting lists and private sector involvement. I do not know of any party in the House that is fundamentally against the idea of private sector involvement from time to time, where appropriate. On 6 February, John came to the Committee to talk about consultant cancellations. You remember that session, John.

Mr Compton: Yes, I do.

Mr McDevitt: It was a pretty robust session. Minister, one of the most startling things was that it was established that a consultant is six times more likely to cancel his or her appointment when working for the NHS than they are when working privately but being paid by the NHS. Given that fact, how is doing it through the private sector more efficient?

Mr Poots: I am not suggesting that it is. I have made it very clear that waiting lists create the opportunity for more private work paid for by the public. By denting those waiting lists and reducing waiting times for people, there is less opportunity for consultants to work in the private fields than there would be otherwise. In one sense, we are paying consultants outside the health service to do work for us; otherwise, the public will end up paying considerably more, and more work will go to the private sector. I should say that Northern Ireland has one of the lowest levels in the UK of private sector opportunity in health and social care. I do not want to change that dramatically. Where there is an opportunity for a mixed model of care that can help us to deliver and ensure that the public's needs are met, we will give that due consideration. However, we are not looking at going down the route of a private service model.

Mr McDevitt: But we know that consultants are good at cancelling appointments. They are six times more likely to cancel an appointment when they are doing the day job, being employed by the NHS, than when they are doing the same job but being employed by the private sector, though, as you rightly point out, still being paid by the taxpayer. Do you not think that the drive to reduce inefficiency should start with getting them to be less likely to cancel the appointments when they are doing the job that they are being paid to do in the first instance?

Mr Poots: Madam Chair, we could be in danger of being on a different page on this. I do not like the way that the system is. I do not like the fact that many consultants can operate outside of the health service, charge significant amounts of money to people and make large volumes of money outside of the service. However, these negotiations do not take place in Northern Ireland. These negotiations take place in London. Doctors existed before the health service existed; doctors negotiated their terms to come into the health service; and doctors have negotiated their terms ever since. Your gripe and your battle is not with me on this issue. I do not like the way that it is, but I am committed to reducing waiting times for people. On occasions that will mean expending money outside of the National Health Service normal system. It is not desirous for me, but I believe that it is necessary.

Mr McDevitt: Chair, I welcome those remarks from the Minister, but you always have to be very careful not to privatise the problem because that just incentivises the problem to grow. I have logged myself out of my laptop, so I will try to remember John's remarks on that day. If I remember, John, you said that there was a risk that we were privatising the problem and that the battle was inside the system, in the first instance, rather than making — building, if you like — a perverse incentive to send more stuff out of the system.

The Chairperson: We have agreed that we will go into more detail on cancelled appointments.

Mr McDevitt: I will move on then, Chair. I have made my point on that.

I have one final question for the Minister. The House took a position on TYC in a recent motion. Minister, will you acknowledge the decision of the House and tell me how that will influence your decisions around the implementation of TYC in the months ahead?

Mr Poots: If people want to spend money on private healthcare, that is their option. There will be occasions when we use mixed models of care; so, for example, we work closely with the voluntary and community sector, which specialises in mental health and learning disability and some other areas. On elderly care, all of our nursing home provision, for example, is currently carried out by the private sector, and around 70% of residential care home provision is carried out by the private sector. Indeed, GPs are private contractors. Do I want to expand that significantly? No, I do not, but there are occasions when we can get more cost-effective care — care that is as good — in the private sector, and we will use that on occasions. There is no mad, headlong rush down the private sector route, and we will only use it when it is pertinent and appropriate to do so.

Ms Brown: Thank you, Minister and officials for your time. I will not keep you for too long, you will be glad to know. Last evening, I had the pleasure of spending five and a half hours at the new Antrim A&E, and it was not an official tour. I did not expect to have to go, and I had a very positive experience. The full five and a half hours was spent not waiting but in treatment and care. The staff were fantastic, and it was good to witness how everyone else was dealt with during that time. It seems to be working very well from what I could see last evening.

My concern is in relation to how information goes from hospital to hospital and hospital to GP, the time that that takes and the method of communication. My biggest concern is about whether the information actually passes at all, because, from my experience in the past two weeks of attending two different A&E units with a family member and going back and forth to a GP in between, I have found that very little, if any, of the information that I have seen has passed to anyone. That is a big concern to me, and, from sitting on this Committee, I am aware that a lot of the tests that were done were unnecessary because they were done on the first occasion and did not need to be done the second time, the third time or the fourth time. I know that electronic records will be rolled out at some stage. Perhaps you could update us on how Transforming Your Care is going to deal with that issue. I am sure that the job of admissions departments would be made much easier if they had all that information available to them.

Mr Poots: The investment in electronic care is, in my view, a very wise investment of £9 million. It should deal with the issues that you have just raised and the experiences that you had recently. I understand that the final roll-out of electronic care records will take roughly three months, and, at that point, all of Northern Ireland should be linked up. Your records should be available at each hospital, no matter what hospital you go into. As soon as your details go onto the record, they will become available to your GP, and your GP's notes will be available to the hospital.

The electronic care records will create opportunities to do a lot of things in public health and a series of other areas. That key area, where people are testing where they should not be testing — blood tests, for example — should be eliminated as a result. I hope that that element of the experience is something that you will not have to go through again.

Mr Compton: The extensive piloting that we undertook before its introduction proved that very point.

The Chairperson: Another pilot. You are like Aldergrove, John; you are full of pilots. *[Laughter.]*

Mr Compton: We had to get the clinicians and others to agree on that sort of situation. That very point was raised — that if a general practitioner had undertaken a blood test and the patient came to an outpatient appointment within a prescribed period, that result would be used and the test would not be redone, and vice versa with the general practitioner's consultation.

From our perspective, the electronic care record is a game changer in how we manage and look at the future of health and social care. The ability to provide real-time information to clinicians who are dealing directly with you must enhance the quality of care and make it more efficient.

Ms Brown: I assume that the practical outworking of that will be useful to clinicians too. In watching all that was going on, I saw the amount of paperwork and recording that nurses and doctors have to do. That is obviously a drain on them, but the new system will make life easier for them as well.

Mr Compton: It will certainly reduce all that and make life easier, yes.

Ms Brown: Never mind cutting down on the pincushion effect on the patients who are having to undergo tests that they probably should not have to undergo.

Mr Poots: The electronic care record (ECR) is just one element of it. I have an aspiration to remove a lot of the hand recording that currently takes place. For example, my understanding is that currently it can take an hour and a half for someone to be admitted to hospital because of the work that an admissions clerk has to carry out. If we can do more electronically, we will be able to move through the pages considerably quicker and reduce that. We also have nurses who are recording on the ward and who have to go back to the nurses' station to record again. We will need to look at how we can invest in systems that are robust enough to ensure that we have all the information so that it does not impact on patient safety. We also need to ensure that it does not have an impact on hospital-acquired infections. There is considerable work that can be done there, and I am encouraging people to be innovative in bringing something forward on that.

The Chairperson: OK. Members, please move your tablets away from the mics because they are interfering with the recording and you cannot be heard.

There was a report this morning about accessing patient records. I know that it was based on a review that is taking place in England, but pharmacy access, the day of the week the patient attends a hospital and patient records could have an impact. Are you looking at those issues as well?

Mr Poots: Yes, we are looking at who should have access to patient records. The truth is that, sometimes, some of the GPs think that the records are theirs. The GPs may have done the vast majority of the recording, but they are the patients' records, and that needs to be recognised. Given that we have to have full confidentiality in the system, who should the records be available to? It needs to be appropriate to the patient's needs. If a patient is seeing a physio on a regular basis, the physio might be the person to whom those records should be available. If the patient is working with a specialist nurse, the specialist nurse should maybe have access to them. We are considering how to make full use of the records and make them as widely available as possible whilst ensuring that patient confidentiality is not impacted in any way, shape or form.

The Chairperson: Specifically, what about the report on A&Es in England?

Mr Compton: The issue is about the availability of information. If you do not have information or the pharmacy does not have it, it creates complications. Inside the hospital arrangement, the ECR records will be properly available to the professional groupings. We have gone through extensive work with all the professionals because, quite rightly, the professionals wanted to understand that they, and not somebody else, designed the information that they thought was important and to understand the clinical issues about sharing that information. We have reached a good accommodation with all the parties involved, and, as the Minister said, we are rolling the project out. We will be fully operational shortly. That is the beginning of a transitional process, because we will have to think about where we take it in its next steps and next stages.

The Chairperson: Another pilot.

Mr Beggs: Thanks for coming to inform us more about TYC. There is a lot of jargon, and, as others have said, the public does not really know what it is about. Hopefully, it is about improving patient care. I see it as trying to empower a range of professionals to use their skills to bring about that improvement by allowing earlier intervention and taking away the bottleneck that exists at our hospitals at present. The one pilot that springs to mind is the ENT pilot at Holywood Arches health centre, and all the reports are that it was highly successful. It has closed, and we were told that it was being evaluated. Has it been evaluated? Are you looking at how to prevent us operating a stop-start system and to ensure that there can be an ongoing funding process when there are encouraging signs, so that we do not have 35- or 45-week waiting times for ENT services in Belfast?

Mr Compton: The short answer is yes. The scheme that you are talking about would not have materially affected the waiting times. It affected a small number of people. The issue is to learn how to do those things sensibly and properly and whether there are any issues of patient safety and professional agreement between specialist doctors and the primary care doctors. It is important that you do all that work to get there, but we have confirmed a number of projects that will be running out in dermatology and in other areas across Northern Ireland. With the integrated care partnerships, the ability to keep in primary care those things that should remain in primary care is at the core, but we must give primary care the skills and ability to deliver the tasks and make sure that if someone has an ENT problem of significance, they see the individual who can deal significantly with it. That requires the doctors to talk to each other and requires secondary care consultants and primary care consultants to agree the correct referral patterns and the correct clinical presentations. All that work is ongoing.

Mr Beggs: Has that evaluation been published? Is there transparency about it?

Mr Compton: As I said to you before, the evaluation of that is with the Belfast local commissioning group because that is the commissioning body that did it. I do not have the information directly to hand, but I can get it to the Committee.

Mr Beggs: When you have positive signals, are you looking to keep operations running rather than stopping them and doing an evaluation?

Mr Compton: In a pilot, we say to people at the outset that it will run from x to y and, at that point, we will evaluate it. It is quite clear. Your point is that we must not stumble into it in such a way that it appears to the patient or their family that, in some way or other, they will not get something at a future date that they were getting. That seems curious and strange to them. We need to be clear about that.

Mr Beggs: Minister, you talked about perhaps having to invest more time in domiciliary care for patients. I think that most people would probably struggle to get up in the morning and be washed, prepared and dressed in 15 minutes, yet we expect the elderly and disabled to have that support for 15 minutes, and then their carer leaves. It is really quite a tight time frame. We have picked up in correspondence that there have been suggestions recently that calls should be reduced to eight minutes. Can you give us reassurance that there is no such plan?

Mr Poots: We are actually putting more money into domiciliary care than was previously the case. It is not an area that is being cut. However, there is greater demand, so that is a pressure that has to be met. I am not sure where the suggestion for eight minutes came from, but it is not something that has ever come across my desk or that anybody in the health service has raised with me as a model that we should be working towards. I am not sure whether John has some secret plan that he has not made me aware of as yet.

Mr Compton: No. I have heard the eight-minute thing. It is about assessed need. Domiciliary care is a response to assessed need, whatever the assessed need is. I would find it difficult to understand why eight minutes would be a response to an assessed need. To be honest, I find it quite difficult to see how that would operate. As I have said to you, there are always issues. I am happy to follow through whatever information you share with me. All I can tell you is that the money has grown to nearly £9·5 million. The average hourly response to individuals has grown from about 9·5 hours to 10·5 hours. I realise that that is a whole perspective, and there are lots of people who may be getting small numbers of hours or large numbers of hours, but the trend is upwards and the numbers of people receiving care are going up. We are not interested in commissioning a service of ineffectual quality.

The Chairperson: If you have information on that, pass it on to us.

Mr Beggs: It is in our packs. What are you talking about when you mention 9·5 hours to 10·5 hours? Can you elaborate?

Mr Compton: That is the average. If you look at the number of hours that we buy across Northern Ireland —

Mr Beggs: Per week?

Mr Compton: Yes, per week, per person.

Mr Beggs: OK. I will move on to the area of residential care. How are you going to respect the wishes of our current elderly residents in your future plans?

Mr Poots: That is a course of work that Fionnuala McAndrew is currently working on. I do not have any particular argument against the view that the elderly were not shown the respect and courtesy that they should have been in the process that had taken place. That is why I stopped it. I think that we need to go back to what John has just said — people are in residential care homes because of an assessed need. For each individual, if there is an assessed need that they should be in a residential care home, we always have to identify how we will deal with that individual assessed need. We cannot deal with individuals by saying, "We are closing the following facilities". We need to deal with each person, as an individual, as to what their future holds and as to how they wish to see out their years. I think that we have to give due respect and cognisance to our elderly population. I believe that Fionnuala is very aware of that in the work that she is doing. I am allowing her to get on with that course of work and waiting for her to come back to me on it.

The question was asked about some trusts not filling spaces in homes. If we are going down the route of providing different models of care — I genuinely wish that the Committee would visit the latest facility that we opened at Cedar Grove in Downpatrick, because it is absolutely fantastic — that will involve the closure of homes. However, if we are to close homes, it needs to be done in a way that shows respect to the people who are presently in those facilities. I think that there needs to be an element of using those homes for respite care, so that people are not sitting with four or five people in a residential care home and nobody else there, and working with people who wish to stay in those facilities in a reasoned way.

Mr Beggs: Finally, I want to go back to something that the Minister talked about earlier, which was someone taking an hour and a half to do administrative paperwork just for somebody to be admitted to an A&E. The amount of administrative work, generally, in the health service has grown and grown. Are we looking very carefully to see whether it is all necessary or whether some of it is perhaps just box-ticking for some of the former management ideas, which ultimately waste time, serve no good purpose and are in danger of resulting in inappropriate actions? At Staffordshire hospital, its management looked at lots of targets and figures and box-ticking rather than at patient care. Are we ensuring that what we are doing in Northern Ireland always has the patient at its heart?

Mr Poots: I think that too much administration takes place and that too much of our staff's valuable time is taken up doing it. There is a necessity to a lot of it, in that if you do not have a proper trail of records and are challenged in court about something that goes wrong, you can be left completely open. We have to operate within a judicial system. We have standards that are set and overseen by the RQIA, and so forth. So, we have all of that on the one hand. On the other hand, people cannot provide care for others whilst they are writing or typing. They can only provide care for people when they are actually with them. I would love to see a situation where we could have nurses spending an hour more of each shift nursing, because I think that you would see a dramatic improvement in healthcare. That is where we really need to address how we can reduce the amount of time that nurses spend recording; not just nurses, but given that there are almost 17,000 of them, an awful lot of time is taken up doing that kind of work when it would be better spent delivering services for the public.

Mr Dunne: Thanks, Minister, to you and your officials for coming in this afternoon. I have a couple of quick points. Domiciliary care has been mentioned a couple of times. We have a paper from the providers who are concerned about the attitude of the trusts towards their provision. They are claiming that the Belfast Trust, for example, cut the hourly rate by 7% last year and that further cuts are planned again this year. The South Eastern Trust wrote in May of this year that it is suggesting a 3·3% reduction in the hourly rate. How are we going to get a good service from such providers if the trusts are effectively not giving the support and are not seen to be giving adequate support to see through Transforming Your Care? Are the trusts committed to Transforming Your Care?

Mr Compton: The answer is yes. They are committed to it. I think that you are referring specifically to the Independent Health and Care Providers (IHCP) paper.

Mr Dunne: Yes, that is right.

Mr Compton: I think that there are a number of flaws with that paper. I have written to its representative, and we will be meeting in due course about that. We have sent some extensive information, and we have quite fundamental differences with some of the assertions that were made in the paper. Notwithstanding that, there are efficiency reductions or reductions of price, but remember that our total system is being asked to provide efficiency each year. Our providing organisations, for example in elective care, have had a 2% efficiency mandated this year; so with the same money, they will be doing 2% more activity. I do not think that it is unreasonable for us to look and say to providing organisations that we expect them to be as efficient as they possibly can be. Of course, there comes a point where that is not reasonable and not fair.

As I said, I have written to the person who co-ordinates the IHCP to express disquiet about how this matter was raised. My door is open; he can come. This year, for the same organisation in residential care, we uplifted its prices by 3% and did not ask it for any efficiency, which effectively gave it around a 5% lift in price. I do not think that there is unreasonableness on the commissioning side of the house, and trusts in this regard are subcommissioners, to respond to that, but I do not think that how that was handled is a particularly constructive way to sort it out. There is a strong commitment to providing properly resourced, properly funded domiciliary care, but we need to sit down and talk about it and not deal with it in this manner.

Mr Dunne: There are issues to be resolved.

Mr Compton: There are.

Mr Dunne: Integrated care partnerships have been talked about a lot, and there is evidence in your paper on those. What progress has been made on those? That issue goes back to the role of GPs, which we have also talked about a lot. Recently, I spoke to my GP, who did not seem to know a lot about ICPs and did not seem to have really bought into Transforming Your Care. Are we getting the message out to the health professionals and are they engaging as they should on the changes that are coming?

A major issue is the effect that Transforming Your Care will have on A&E departments. We harp on about it, the media pick up on it, and we are all affected by it — our families are all affected by it, as we have heard. That issue is always to the fore, no matter the season or the year. Transforming Your Care has been around for almost two years. By now, I would like to think that there has been significant change. It is an evolving process, but is it evolving much slower than planned? I would like further commitment to try to move the changes forward on A&E departments.

Mr Poots: You have raised a number of issues, Gordon. First, the ICPs are operational. The one in your area is currently operating over the trust area, but it will be splitting into four: one for north Down, one for Ards, one for Down and one for Lisburn. That work is under way. Your GP may be older than you, but —

Mr Dunne: I think that he is younger. *[Laughter.]*

Mr Poots: We find that, generally, the younger GPs are much more enthusiastic about the process of change than some of the older ones, who may be a little more set in their ways. GPs need to buy into this, and we need their support to deliver change, in conjunction with others from a range of disciplines. If we are to tackle the problems in emergency departments, we need to deal with certain issues further back down the channel.

Mr Dunne: Correct.

Mr Poots: GPs may be referring or sending people to emergency departments, but there are far greater opportunities for direct admission. GPs need to be confident in what they are doing and that they are making appropriate directions for admission. Clearly, they have to work with the hospitals on that. GPs need to do a considerable amount of work with us to deliver change. In previous negotiations, we received a commitment from representatives of the body that represents GPs that they were keen to deliver TYC. We will take them at their word and hold them to it.

Mr Dunne: Will you clarify the authority of the care partnerships in relation to the trusts?

Mr Compton: They are networks for provision; they are not commissioning bodies. The local commissioning groups (LCGs) will commission services from them and performance-manage their delivery. They are made up of primary care professionals, including GPs, trust staff — typically nursing or allied health professionals — people involved in direct care, community groups and voluntary organisations such as those that deal with stroke rehabilitation. The LCGs have a specification for the service pattern and they will act directly with the care partnerships using the existing systems for exchanging resources. The partnerships will be held to account on delivery by the LCGs, including reduced admissions to emergency departments.

Mr Dunne: Change is coming down the line very quickly.

Mr Compton: I hope so; yes. All 17 of the ICPs have met. I happened to be in Derry last week and attended the first meeting of one of the ICPs there. It was a coincidence that the meeting was taking place while I was there, so I said hello to the people involved. The ICPs are definitely operating, talking about where they are going and the things that they need to do.

The commissioning specifications have been passed to the LCGs, which are talking directly to the ICPs. We expect the second half of the emergency service changes from September onwards.

Mr Poots: I am constantly chivvying away at my tortoises to speed them up a little.

Mr Dunne: Good. Thanks very much.

Mr Gardiner: Minister, thank you very much for your presentation. Keep up the good work. What area of your Department's remit is paramount in your mind as one in which there is tension and requires more funding? I know that it is a very tricky question, but I would like to hear your views.

Mr Poots: It is not a difficult question. The answer is the care of the frail elderly and our older population. That is the area of greatest growth. We have been hugely successful in ensuring that people are living longer, and we want to ensure that they have a good quality of life to go with that. We want to ensure that people have more healthy years. We must look after our elderly and deliver on public health. That will ensure that our younger people have many more healthy years, as opposed to just more years. We do not want to be incapacitated when we get our 50s, 60s or 70s due to strokes, etc, that could have been prevented. That is the key area. I want to ensure that people have more healthy years and a good quality of life as they reach older age.

Mr Gardiner: Thank you very much. I wholeheartedly agree: we have to look after our senior citizens. They are living longer, but they need that extra bit of attention. Under your jurisdiction, I am sure that they will get it.

The Chairperson: Some people round this table need to declare an interest.

Mr Poots: I think that we are all getting a few grey hairs. Some of the ladies might cover them up, mind you.

Mr Gardiner: They can get away with it. *[Laughter.]*

The Chairperson: I try, but I have an allergy to hair dye.

Mr Poots: It is not cool for a guy to dye his hair.

The Chairperson: Before you go, Minister, I hope that tomorrow is not the day when you will announce a decision on the paediatric cardiac issue.

Mr Poots: No; it is not.

The Chairperson: Will you update us on that?

Mr Poots: I hope to meet the surgeons over the next couple of weeks. Obviously, that work is ongoing. If I had something really positive to announce, I would not wait until after the summer to do it. However, I am not in that position. We are working away on it. Michael McBride is engaged in that

work at the moment. I hope to receive a paper from him relatively soon, probably in the next week to 10 days. I do not think that a decision will be made in the immediate future. If I have bad news, I will probably ring you first.

The Chairperson: Do not be ringing me unless it is good news. I appreciate that. Some parents contacted me and other Members to say that they had heard that a decision was going to be made tomorrow.

Mr Poots: No decision is imminent.

The Chairperson: OK. I appreciate that, and I appreciate you coming to the Committee to tease out some of the issues around Transforming Your Care. Thanks very much.

Mr Poots: Thank you.