COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Health and Social Care Review

23 November 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Health and Social Care Review

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

Witnesses:

Ms Catherine Daly	)	Department of Health, Social Services and Public Safety
Mr John Compton	)	Health and Social Care Review Team
Professor Deirdre Heenan	)	

The Chairperson:
I welcome John Compton again, Ms Catherine Daly, the deputy secretary of the Department of Health, Social Services and Public Safety, and Deirdre Heenan. You are very welcome, Deirdre; this is your first time in with the Committee, so you are particularly welcome, not that we are picking on anybody else.

Professor Deirdre Heenan (Health and Social Care Review Team):
Good. Thank you very much. I see some friendly faces.

The Chairperson:

We have been rushing through today's business, because we were very anxious that everybody would have time to ask questions of you. John, you were in with us a few weeks back, and we look forward to hearing about the progress that has taken place since then. I invite you to make a presentation and take questions from members.

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

Thank you very much. We forwarded a little report to you, so I am just going talk through the pages of that, although I will skip through some of them. You know that the Minister asked for the review to be commissioned in August, and we will be reporting towards the end of next week. The panel members are known to you, so unless you want me to talk about them I will move on.

The objectives of the review are to have a strategic assessment across all of health and social care; to try to engage as much as we possibly can with a full constituency of professionals, the public and interest groups; to make recommendations about a model of care for the future; and to talk about how that model might be brought to fruition by way of an implementation plan. That is the work that we have been doing.

We broke the project into five distinct themes. The first included a literature review, benchmarking, looking at the data on demographics and spending a little bit of time on North/South, east-west relationships. That might be helpful, and we might spend a bit more time on it. The second theme involved doing a presentation on the existing services. We have also used the Department's health economists to give us some high-level economic impact, because we are aware that health and social care is an important economic driver for Northern Ireland. Then we looked at alternative models, and we are now in the process of completing and writing the report. That is the journey that we have been on.

We have gone through most of the things that I have said in terms of engagement and current service provision. Although we have obviously had a relatively short space of time, we have made a very robust effort to engage as much as we can. We have had an online survey, which has just closed. We commissioned an omnibus survey: Ipsos MORI did a structured piece of work by interviewing 1,000 people for us. We have also worked closely with the Patient and Client Council in respect of the work that it does. We ran a series of workshops; they were professionally driven, and they also involved the voluntary and community sector, the Business Alliance and regulatory bodies such as the Northern Ireland

Social Care Council. We have had a whole series of workshops over the period. The workshops finished on Monday past.

Staff consultation is very important. We have had two meetings with the partnership forum, which is the body where staff organisations meet to talk to the Department of Health about relevant issues. Panel members have been there to meet individuals. We have also met the staff organisations individually at their request, because there are some things that are more important in that individual sense. We have had a lot of people asking to meet us. We have tried to meet about 90% of those groups, individuals and organisations across the whole period. We have been out to all of the trusts. We have met a variety of voluntary groups, interest groups and independent sector groups, and a whole set of individuals.

A series of debates and cameos about health and social care in Northern Ireland will be in the TV and media this week and next week. The whole objective is to try to stimulate a conversation in the Province about the issues that health and social care is facing in the context of a report being presented. We have had a series of public events, the last of which is in Armagh this evening. Those public events have taken us around the Province variously to Derry, Omagh, Lisburn, Ballymena and Belfast. We also met the council down in Enniskillen, and it invited members of the public to attend the meeting, so I suppose that that qualifies as another public arrangement.

We try to get over to people five key themes in the case for change. It starts with quality. We know a lot about quality in our services and outcomes. However, we have perhaps not quite moved to organising our services to respond to that quality information. When you do this, it is sometimes implied that you are making a critical comment on what is in place. That is clearly not the case. The review is about the future and getting a model that fits the future. No one should be concerned that we are making any comment on the immediate service or the immediate past.

The second key theme is prevention. Most people want to be well and healthy. We often have to deal with the results of things that are preventable, so we need to talk seriously about prevention. Resilience and sustainability is another key theme. We have to have a service that is both resilient and sustainable. It must be one that you can appropriately staff and that meets all the staff criteria. There needs to be recognition that Northern Ireland, with a population of approaching 1·8 million people, is a little small to run a complete health and social care system. That requires us to look to support arrangements, particularly North/South and east-west. We have met colleagues in the Southern jurisdiction to explore what might be

the sensible way forward.

There is a little bit about demand. Internationally, there is an observation that 5% of the population will spend up to 50% of the money. That is not to be critical of the 5%, because we all have the entry ticket to join that 5%. If we do not understand, recognise and work on that, the system, whatever it is, will run into difficulty.

Finally, there are issues of resources and how we handle resources. We explain that and talk to people in those terms. To give a flavour of some of the things that people have said to us and asked us to reflect on, I would say that as a general rule the focus of 75% of our discussions and debates with every single group of people, whether professionals, the public or interest groups, has been on how we organise services for older people.

Mr Gardiner:
Senior citizens.

Mr Compton:
Yes, senior citizens.

Mr Gardiner:
Please use that term in future.

Mr Compton:
Right, OK.

That is entirely reasonable, because it is a real issue for us. The sorts of things that are said to us are, "We would like more personalised care." When you push that a little further, it seems that people would like more control over the resources, how services are provided and the choices that they have. There are some choices then about what we do with accommodation. Do we provide it? Do we not provide it on the statutory side? How do we organise intermediate care, such as step-up step-down beds in services? How does primary care provide services to that population? How does it do that in a way that is sensible and reasonable? How do we understand how hospitals provide care to senior citizens and all of that situation? That is the issue. Those are the themes that have come very strongly to us.

On primary care — and this is not exhaustive, just a flavour of the things that are there — there is a lot of discussion about how dentistry is organised. Can oral surgery be more local?

Can the dental contract move away from an item service payment to the more collective population arrangement? Should there be a re-orientation of community pharmacy, in particular, to give a proper and expanded role to community pharmacy, which is a very vital service in the delivery of health and social care? How do we work on the 5%/50% spend, particularly with our primary care and general practitioners?

On mental health and learning disability, uniformly, people have said that the Bamford report is a good piece of work and will we please just get on with it. That is essentially a synopsis of what has been said to us. When we get into prevention and well-being, there are issues — the Sweden Jönköping approach — and that is more to do with engaging communities and using them more powerfully to drive the preventative agenda, as opposed to people coming and saying, "This is what you should do and it is better for you." Get connected to communities; get the communities to take the lead role in that.

There is a very strong feel for what is referred to as joined-up government. For example, some people have said to us that if you are at home, 80 years of age and receiving district nursing services, you rarely complain about the district nurse or the GP. What people complain about is having to lock their front door at night because they are afraid of someone breaking in, or that they do not have transport systems that will help them. So, in doing the review, we were asked not to forget all of that care stuff that works, to say something about that and to make it real, because everybody says that joined-up government is a good thing, but can we personally experience it? That is the question that was pushed as far as that is concerned. That means how we work with other parts of government.

In the children's area, the theme is Head Start. That is really about dealing differently and much more comprehensively with the period from pregnancy to age five. It is about prevention and avoiding the difficulties and problems that are around. A second theme is child and adolescent mental health services, and in particular tier 4, that is the hospital services and how they are organised.

The final area that I will reference this afternoon is in paediatric hospital services. Can we get them to be in a better shape or structure? With hospital services, the issue links back to quality and outcome. If you know what the quality and outcomes are, for example, in stroke services, can we organise our services to deliver that outcome? That means that, if we ask people to travel, we have to ask them to travel for an outcome, not because it is convenient for someone else. We should clearly link any of those changes to outcomes.

Questions are asked about how many hospitals we require, where they should be, and all of that issue. The themes are that there is no such thing anymore in Northern Ireland, and probably not even in the UK or down South, as an individual hospital that is an island unto itself, in the sense that it can provide every element of service. There is a strong push for networks and hospitals working in a much more joined-up way. When you come to all that and to the money and policy side of things, people can understand how it is more preventative or how we might want to do things in a different way for different client groupings, but how are we going to sort this out and how we will pay for all that? The question is whether the review should reflect on targets. For example, we spend 42% of our money in hospitals.

We probably overuse hospitals as services. I think that there is a fairly strong consensus that that is the case, which is because, in many instances, hospitals are the only services available. That is not a criticism of hospitals. However, should we suggest that we move the 42% that is being spent on hospitals to 38% or whatever, and signal in the review that the money released by doing so will be reinvested in the other programme areas in which you want to make a change, by communicating to the public that you are making a change here to get to there, and that you want to make such a transition, you are beginning to communicate how that change would happen. Of course, that brings in workforce issues and where we stand with the workforce. Although I think that there will be changes in and challenges for the workforce, the review will not be recommending wholesale redundancies or anything like that. There is a lot of speculation about that, and there is stuff in the press from time to time. That is not the issue. We think that the workforce is a good one that needs to be trained and is willing to do things into the future. It needs to be able to get on and do some of the things that it frequently wants to do.

Transport and infrastructure were two of the themes that came through in the public meetings. People were very concerned about transport. Occasionally, but not often, people asked about structures and organisation. Issues were raised about primary care and particularly general practice — how it works and people's experience of it. There was strong support for more mental health services. There was also very strong support for better communication — a better and consistent engagement with the public about why changes have to be made and the nature of those changes. At any of the public meetings at which panel members were present and we discussed various issues, once people had debated and had that sense of understanding, rarely did they resist the information that clearly explained why something would be better if it were organised in a different way. Workforce, training and a little bit about maternity services — including how they would be organised — also emerged as themes. Those are a flavour of the themes.

We will produce our report. It will go to the Minister. It will then be for the Minister to take the matter forward as he deems fit. I will pause there.

The Chairperson:
Thanks, John.

Mr Brady:
Thanks for the presentation. I will be totally parochial and start by simply saying, “Daisy Hill”. A BBC radio report yesterday morning by Marie-Louise Connolly specifically mentioned Daisy Hill Hospital. Does the BBC know something that we have not been told? Is there any basis for what she said? That is the first thing that I want to ask you.

Mr Compton:
The answer is no. In fact, the local council wrote to me earlier today to invite me to visit it tomorrow. Had I not had commitments that I cannot rearrange, I would have gone. Any comment in the press at this time about any individual facility or issue is simply speculation. There has been no prior briefing to anyone to say, “Here’s a heads-up for what’s happening”, or something of that nature. That is certainly not the case.

Mr Brady:
So you are reassuring the Committee and me that there is absolutely no basis for what was said, because it was also repeated on the early evening news.

Mr Compton:
I understand that. Yes, I understand.

Mr Brady:
You can imagine the consternation, indeed panic, that that caused not only among staff at the hospital but among people in my constituency.

Mr Compton:
I do understand that, and I think that people have to look to why they do those sorts of things. Other than that being speculation, I can simply say to you that nothing has been said on the part of the review, the review team or anybody associated with the review that would have informed that report. I think that it is a matter of fact, however, that when a review such as this is conducted and it comes towards the end of the process and is close to being handed to

the Minister, people will form views. They will want to say that they think that the review will have this in it or that in it. I assure the Committee that, if we have anything of substance to say to anyone outside of that, we will say it properly and appropriately, which does not mean that we will tell the press before we tell the Minister and others.

Mr Brady:

Given the sensitivity and importance of the review, people who speculate and pick out a hospital cause consternation and panic. The old saying is that there is no smoke without fire, as you can imagine. In an interview yesterday morning, you talked about people in the North having — correct me if I am wrong — a love affair with buildings. To be honest, I thought that that was slightly patronising because it is about what is in the buildings and the service they provide. I do not think that people necessarily have a "love affair" with bricks and mortar; it is about the services that are provided there and how effective those services are. Such comments are sometimes not helpful because, before your interview, a reporter talked about Daisy Hill in particular. In the wrong hands, two plus two sometimes makes five and, rightly or wrongly, it was almost like a sequence. Perception is everything, and the perception is that someone will not go on the radio and mention Daisy Hill unless he or she has been told something. If they have been told something, I find that abhorrent.

Mr Compton:

They have not. It is as simple as that.

Mr Brady:

That is fine. If you are reassuring us today, obviously we accept that. However, that message needs to go out because it is very worrying.

Mr Compton:

That is what I communicated late this morning to the council when it asked me to attend a meeting yesterday. I said that I would come to the meeting — I have no difficulty with that — but that, at short notice, I cannot —

Mr Brady:

I understand that. I put a question to the Minister in October about the extension of A&E services in Daisy Hill. There was some delay but it was more to do with the provision of patient monitors and training, and, as far as I know, it has been up and running since 1 November. That cost a fair amount of money and, on the back of that, there is speculation — you have now confirmed that it is speculation— and all of that does not help.

Mr Compton:

People can have a view about whether that was the correct phrase for me to use, but it was quite deliberate, because it is about services. In my view, it is not about a building at all; it is about services. However, when we talk about services inside a building, people never have a debate about the service but rather the retention of the building. The point that I was trying to get across — if it was not put across well, I accept that — is that buildings are not the issue at all. The issue is the service and, more importantly, the outcome for individuals who receive that service. So what is the best way to organise services so that individuals who receive them do so with the best possible outcome? We have a substantial amount of information that tells us what works and offers the best possible outcome for individuals and patients, and that is at the core of what the review has been about.

Mr Brady:

I think that it is accepted that Daisy Hill provides a quality service. It has done in the past and continues to do so. I go back to my earlier point: many people may consider such speculation irresponsible.

The Chairperson:

The fear is that A&E services in Daisy Hill will be downgraded. That seems to be the weak underbelly. I have spoken to people about that, and there is concern. John, you talked about quality outcomes, which is what we want, and also mentioned a population of about 1·8 million people. If there is a model somewhere in which a hospital that services 1·8 million people with a single A&E department is the all-singing, all-dancing model, I can assure you now that that will not work here, and we will not accept it. We need recognition of geography and demographics, and people in the Daisy Hill area feel very vulnerable at this time because they are looking at services in other places and at what is likely to go. So we are not scaremongering; we are trying to be balanced, objective, reasonable and fair. However, we are very concerned.

Professor Heenan:

May I make a comment to provide some reassurance? The review panel was particularly struck by the issue of rural accessibility. We had an idea that the review would focus largely on hospitals and A&E services, but, in fact, from the public meetings and the information that has been sent to us, a key issue in Northern Ireland is its geography. There is a concern that we should not take a model from somewhere in the south of England and parachute it over to Northern Ireland and see how well it works because, on paper, it seems to work very well.

There are particular issues in Northern Ireland of which we are well aware. Around the Newry area, there are people in Katesbridge, Ballymoney and Rathfriland who are very concerned that their services are going to be removed. Some of those people are saying, “We are 17 miles away from an out-of-hours service. Are you seriously thinking of removing services?” I have to reassure people that the review team is very cognisant of the rurality issue and services for people living in rural communities, and even people who live seven miles away, because it could be seven miles on a bad road and they may not have access to transport. That has come through as a strong issue for the team.

Mr Brady:
I want to finish my comments on Daisy Hill. It is regarded as the most efficient A&E department in the Southern Health and Social Care Trust area and in the North for waiting time targets. Over 95% of A&E patients are seen and discharged within four hours. The catchment area has extended because of the downgrade of the Downe Hospital in Downpatrick. The hospital originally covered Kilkeel, Drogheda and Crossmaglen, but it now takes in Dromore, Castlewellan and Newcastle. That service is provided.

You mentioned accessibility, and the protocol for stroke/cardiac lysis injection is available within the time frame outlined by the face, arm, speech, time (FAST) procedure, which reverses the effects of a stroke. That is another major plus. You also mentioned geography. Obviously, with strokes, the sooner a person is seen, the better. We had an Adjournment debate recently on the Ambulance Service, and Daisy Hill is available and accessible to a wide hinterland; the A&E department is probably regarded as the most efficient in the North. That should reassure people, but it was counterbalanced by what we heard yesterday. In addition, trolley waits are virtually non-existent because staff are efficient. There is also direct admission to wards by GPs, which makes the system more efficient. Other hospitals in the North do not necessarily have that system. I want to make those points, because they reinforce what you are saying. I have still to decide whether it is more reassuring or not, but if people are reassured that there has not been any talk about Daisy Hill specifically —

Mr Compton:
We have not talked to the media about any individual hospital.

Mr Brady:
I do not wish to labour the point, but it is important.

Mr Compton:

I am happy to make the point. I will also reinforce Deirdre's point. In the report, there will be a clear recognition that, although best practice from wherever can be considered, in the end, whatever model of care is designed for Northern Ireland has to work in Northern Ireland. So it has to take account of the Northern Ireland perspective. That is not a licence to say that everything as is remains as is. The purpose of the review and the reason behind it is that we know that the "as is" model — if you want to call it that — is simply not sustainable for the future. That is not a licence to say that what works in the south-west of England, the South of Ireland or Jönköping is the answer for Northern Ireland. We can certainly learn from those areas and their issues, but we have to shape and mould a service and make sure that it is fit for purpose in a Northern Ireland context. You will see that reflected in the approach that the review team has agreed to undertake in designing a model of care for the future.

Ms P Bradley:

I want to come in on what you said about the love for buildings in Northern Ireland. When I heard that on the radio, I could not agree more. When you were speaking, the first thing I wrote down was "services, not service". In my constituency, we had closures at Whiteabbey Hospital, which gave a wonderful quality of care but did not give the quantity of services that were required. It was not efficient to have those services there when we had Antrim Area Hospital and the Belfast Trust beside us. That is all I want to say. In this country, we focus on what we know and what we are comfortable with. Change is sometimes very difficult for all of us, but change is sometimes good and is what is needed.

Mr McCarthy:

I will talk not about change but about mental health and learning disabilities. The Bamford review is mentioned in your emerging themes. Will the review recommend the full implementation of the Bamford review on mental health and learning disability, and will that include the required level of resources being made available for good community service for people with a learning disability and mental health difficulties?

Will there be a clear emphasis on the full range of public health initiatives and the associated cross-departmental working? In your presentation, you talked about joined-up government. Will that underpin every aspect of the review, and will that include provision of the required resources for public mental health initiatives, including government-wide programmes to tackle the discrimination, stigma and social exclusion that goes with the issue of mental health?

Mr Compton:

The review's terms of reference make it clear that we were not to stray into two areas: organisational design and resources. However, the Minister has made it clear that, if, in the design of anything that we think should go forward constructively and well, we feel that we should make some comment about resources or organisational design, we are free to do so. Therefore, the review panel will take the opportunity, if it deems it necessary, to say something about resources on a more generic level and if it thinks that that is the important thing to do.

The second area is on the point that I was trying to cover about the reshaping of how we spend our budget of roughly £4·7 billion. If, broadly, we spend a little too much on our hospital services, one way in which we need to be able to fund areas such as mental health, learning disability and other services is to get that proportion into the right way. I indicated that the review team is considering whether it should talk about target direction figures for spend in various areas. If that were done, it would necessarily mean that a little more would be spent on mental health and learning disability.

I do not think that you will be disappointed by the report's comments about the positive nature of getting on with the Bamford review, but, as I understand it, that cannot be read as an open and blank cheque to spend outside a given parameter. We have a sense of the parameters of what we have to spend, so, as far as we are able, we will clearly do that and do it at a speed that hopefully will accelerate a little of the improvements in mental health and learning disability.

Professor Heenan:

That theme came through strongly from the public feedback. Essentially, the public were saying that we have had the Bamford review and do not need another review. They said that we know what needs to happen and asked why we cannot just get on with it. There is disappointment in communities that that report seems to be sitting on a shelf somewhere.

The emphasis on the community and voluntary sector in that area of healthcare came through strongly. People said that voluntary groups are doing fantastic work on recovery from mental illness but that they are working on a shoestring. Those groups came along to say that they are doing all sorts of work and running all sorts of schemes but are being asked to do more work with less. They said that that is simply not sustainable.

Mental health service users said that they would like their services to be more local and

more accessible because that addresses the whole issue of stigma. That has come through strongly in the report, and, without labouring the point, individuals said that we should remember that we are dealing with Northern Ireland. The Troubles are over, but the 30 years of conflict have cast a long shadow over the mental health of many people, and that has to be accepted and dealt with.

Mr McCarthy:

I am encouraged by what I hear. You will agree that mental health has always been the Cinderella of the health service. Everyone in Northern Ireland has agreed on that for years and years. The fact that the issue has been brought up is encouraging, and I hope that, when the report comes out, the recommendations of the Bamford report will see the light of day. I remember the Bamford report being launched in the Stormont Hotel, and a cross-channel Minister was responsible for health. There was no money whatsoever to go with it. Almost 10 years later, we are struggling. I am glad to hear what you said.

Mr Compton:

An important point about the review is that I do not want anyone to assume that, in discussing the review, we have some commitment for some fantastic amount of money. We do not have a commitment for any amount of money. We are talking about how we use the existing £4·7 billion to best effect. We know that we do not always do so and will not always do so in the future, and that means that we require change. In a way, it is joined up because we are quite clear that we need to do more in the areas of mental health and learning disability. I do not think that there is anyone who has not been persuaded of that, but we need to think about how we do it, which means that we need to think about how we spend the money that we have in a different way.

Professor Heenan:

Another key point about mental health is the issue of prevention. John mentioned that prevention has come out as a key issue for the review, and nowhere can that be seen more strongly than in the area of mental health. People say that we need the services to deal with mental illness, but we also need services to ensure resilience in mental health so that people know the indicators; parents can be well equipped to deal with their children’s emotional issues; and individuals can deal with anxiety and stress before we reach crisis point. At the moment, the difficulty with our system is that intervention happens when we reach crisis point; we are saying that early intervention is vital.

Ms Catherine Daly (Department of Health, Social Services and Public Safety):
It is important to highlight the issue of resources. We are all clear on the extent of financial constraint not just in the DHSSPS but across the public sector and the economy. A key focus of the review is to look at how resources are spent and to ensure that they are spent in the best way in the delivery of effective services. We are clear that, if things continue as they are, that would not be sustainable. That is a key element of the review.

Mr Wells:
It is hard to believe that we are one week away from the reporting date. I said that if you delivered in time, there was a knighthood in it for you, so you never know. *[Laughter.]*

Mr McCallister:
Let us hope that you can deliver that. *[Laughter.]*

Mr Wells:
However, to be serious about the matter, that is a very short time span. You must have some idea about the direction that you are taking. I have asked you privately, but it is important that it goes on the record: there was a leak to a television station last week, which alleged that the Mater Hospital's maternity unit would become a midwifery-led unit as part of the review. Some people were quite suspicious that, in order to cushion the blow for the public, strategic leaks were coming out of the team in order to make the results easier to accept. Was there any relationship between that announcement and your review team?

Mr Compton:
No.

Mr Wells:
So where do you think it came from?

Mr Compton:
I think that it goes back to what I was saying: people will speculate about things that perhaps have been in the public arena over a period of time. They will say that the issue may come out in the review. All I can do is speculate about the speculation, which is not very helpful, to be honest, but I can assure you that we have not briefed anywhere.

Without going into too much detail, I do not think that it is helpful simply to enumerate a list of facilities in Northern Ireland and specify this facility here or that facility there. That is

not what the review is about. If a model of care is built that starts with the individual and how the individual experiences services, and that is aggregated to a population or health economy, that is when the service configuration is recognised that that health economy needs to deliver a quality service for that population. I think that that is a better approach, and that is the approach that the review team is reflecting on.

Where are we are now? We have a major meeting tomorrow. The entire review team is meeting in Belfast tomorrow as an editorial board, or whatever you would call it. There will be speculation; we cannot stop that, but I can say that we have not fed that speculation in the way in which it has appeared.

Mr Wells:
I am not a prophet, but I suspect what is going to happen over the next week is that somebody from, say, Coleraine will be outraged about an alleged leak, and so will somebody from other parts, perhaps Newry: none of that will be coming from you in any shape or form?

Mr Compton:
No. Absolutely not.

Mr Wells:
I am interested in your response to my previous question. Are you indicating that the report will not name facilities and that it will be broader than that?

Mr Compton:
I am really uncomfortable about going any further than I have gone, to be honest. The report is for the Minister. It is for him to see in the first instance rather than for me to indicate anything further than what I have said.

Mr Wells:
I am interested in the choreography. You deliver the report to the Minister on 30 November. Some of us were under the illusion that we would wake up on the morning of 30 November and that it would be published, but that will not happen. You will deliver it to the Minister, and I understand that the Minister will then make appropriate steps to inform the Assembly.

Mr Compton:
That is my understanding.

Mr Wells:

How do we ensure that we do not open the pages of a certain local daily morning newspaper and find the report several days before Assembly Members have even had an attempt to be properly informed?

Mr Compton:

All I can tell you is that we have taken fairly strenuous steps to make sure that, when the information leaves the review team, it will go to the Minister. The public presentation of that will be by the Minister at a date of his choosing.

Mr Wells:

Will resources be indicated in the report as to the amount of money that is required to deliver it? In other words, will you give an indication to the Department as to what it will cost for all your recommendations to be worked through the system?

Mr Compton:

It would be fair to say that, if we are describing an implementation plan, which is the process by which you make the review a reality, it will have to make some observations on that. That is just common sense.

Mr Wells:

Hopefully, it will not be leaked. Chance would be a fine thing. Let us say that none of it is leaked and perhaps the Minister makes a statement or whatever in the Assembly. What then happens? Where do we go from that point?

Mr Compton:

It is for the Minister to decide what the next steps are at that juncture. I assume that he will take a decision about whether he wishes to endorse the report, whether he wishes to consult on it and in what shape or form he wishes to do that, and how he would wish to implement the report and the manner and method by which he thinks that it should be implemented. Those decisions will flow from the Minister.

Ms Daly:

The intention is that the Minister will receive the report and will consider its recommendations and conclusions. Given the significance of the issue, the Minister will want to bring that to the Assembly. His intention will be to make a statement to the Assembly on the review report and his views on the recommendations. The Minister will then consider

future consultation in respect of what the report says, whether, in fact, he will consult on the report, or whether there would be various elements coming out of the report that would require consultation. Again, that would be when the Minister receives the report and sees what it says.

Mr Wells:

The media are telling us that the statement will be on 12 December. Is that correct?

Ms Daly:

We expect that the Minister will want to make a statement around that time.

Mr Wells:

So there will be a long pregnant pause between the handing of the report to the Minister and the public knowing?

Ms Daly:

Perhaps John wants to say a bit more about that. Certainly, the timescale for this is 30 November. There will be some tidying up and report writing, and so on, to put together. The timescales are actually very short if the Minister makes a statement in early December against the finalisation of the report at the end of November.

The Chairperson:

The Minister will take it to the Assembly, but that will be the Minister's interpretation of the report. When do we expect to get a copy of the report?

Ms Daly:

Again, I expect the Minister to engage at the earliest opportunity with the Committee on this issue. The Minister will want to bring an issue of this significance to the Assembly as quickly as possible. I expect that he will subsequently make himself available to the full Committee. I expect that the Minister will brief the Chairperson and the Deputy Chairperson about the statement in advance of making it.

The Chairperson:

However, the statement is one thing and the report is another. It is the report that we are anxious to get our hands on. If the Minister's interpretation of the report is in and around 12 December, we do not know at this stage how much longer it will be before the report is made available to the Committee. I cannot say at this stage. As I said, the timing of the report's

conclusion is extremely tight.

Mr Durkan:
I welcome John, Deirdre and Catherine. I am sure that you are exhausted now that you are nearing the end of your engagement, which, I hope, has been exhaustive as well as exhausting.

I do not see any mention of the unions in your presentation. I wonder whether there was any engagement with them or whether they were included in your engagement with the voluntary and community sector or the business alliance.

I went along to the workshop in Derry. One thing that heartens me, from listening to the panel's evidence previously and to plenty of radio interviews, is that the answers appear to be evolving. Although the questions are usually similar, the answers are changing as time goes on, and I hope that that is indicative of the fact that the panel is responding to the consultation. I hope that the outworking of that is reflected in the review's recommendations.

It is vital that the panel take a holistic view of health and social care provision, the inextricable link between different areas of that provision and the effect that an impact in one area will have on another area. An impact on a pharmacy will have an impact on a GP, which, in turn, will have an impact on a hospital. Just now, we talked about the impact on various hospitals should services be provided in some areas but not others. Today's earlier sessions focused on the need for increased social care, particularly for senior citizens, and the massive savings that that would realise elsewhere in the service. I believe that additional expenditure will be required, and I raised that point in the previous session, but I worry that the money is not there now. We recognise the need for change, but it seems that we are being required to save to invest rather than invest to save. We seem to have that back to front, and I am worried about a vacuum being created in the interim. I wonder what the panel's views are on that.

For the sake of consistency, I want to keep North/South co-operation on the agenda and, particularly, the important role that it has to play in border regions and border hospitals. I echo the earlier concerns raised about Daisy Hill. Yesterday, I took a few calls from party colleagues from that neck of the woods. They wanted to stress not only the capability and accessibility of Daisy Hill but its viability. I want to push the point, which Kieran touched on, about the need for recommendations for enhanced cross-border co-operation. Will the panel recommend more cross-departmental collaboration, particularly on community-based

projects that are vital in areas such as mental health? Such projects are very much part of the preventative measures required.

Mr Compton:

Perhaps the process was not accurately explained to you in the presentation earlier. I should point out that we also had a partnership forum and met staff organisations. There was, therefore, extensive engagement with staff organisations as part of and throughout the consultative process.

I think that we face a financial conundrum. We know that the model as is will not sustain; it will face money difficulties, problems and pressures. We are in a difficult financial climate overall, so any new model will have to grapple with money issues. However, I believe that a new model would be better placed than the current one to do so.

There has been quite extensive engagement with colleagues in the Southern jurisdiction, and they have offered much positive support. I want to be clear about what is being talked about and about the purpose of the conversation. In the past, we tended to have very constructive relationships but only on a single issue, as and when one emerged. The issue is whether it would be better for us to have a stronger ongoing engagement so that we do not end up talking just about a specific problem or difficulty. Colleagues in the Southern jurisdiction approached us about how the opening of the Enniskillen hospital might help them and about the whole cross-border and border community issue, and that makes great common sense.

I do not want to reopen the Daisy Hill issue. *[Interruption.]* No, I want to make an important point. I emphasise that this is not about Daisy Hill. If it had not been Daisy Hill in the press today, I am absolutely sure that mention in the press of any facility in Northern Ireland would have elicited the same response of concern, worry and anxiety. The issue for the review team is to explain that the reason for making any change is that the outcome will be better for the individual. That is the real issue behind the review: when we drill back into the system, the as is model is not sustainable. We can choose to go with a new model in a planned and orderly way. Any change that would occur in any situation would not be dramatic, in the sense that it would not be the equivalent of switching a light on or off. Change would have to happen in a sensible, responsible and timely way. Nevertheless, the issue raised touches on the issue of change for a better outcome. A great deal of information tells us what works better in stroke care, emergency surgery care, paediatric care and obstetric care.

Dr Ian Rutter is one of the other panel members, and he would say — this is not a comment on hospitals — that one of the greatest challenges for a health and social care system is to reduce the diversity of response that individuals receive when they access the healthcare system at primary or secondary care level. At the moment, such diversity is much greater than it should be. With a better sense of organisation, that diversity would narrow and produce a better outcome. I do not expect the debate on, and challenge of, change to be easy or straightforward.

Professor Heenan:
Mark, it is worth saying that we are unique in the UK in having a joined-up system of health and social care. Although health issues always seem to dominate the agenda, the review revealed that people are very concerned and confused about social care. They do not know what is on offer or how to find out about it. People do not know what to expect and are unsure whether they are receiving a quality service or whether alternative services are on offer. They want more empowerment in that area, whether in the form of more choice, more control or more information. It is a huge concern.

It is also important to stress that the majority of people are not frequent users of the service and say that they have little interaction with it. They worry about services not being available when they need them or that they will be expected to pay for them, and they question whether that is fair. There is an issue about what kinds of social care are on offer. Quite rightly, you note that a number of reports published this week highlight social care issues, the quality of the service available, how we benchmark what is available and how we promote a social care workforce in which individuals feel that they are part of a workforce and are valued as healthcare professionals.

Your second point was about joined-up government. It is clear to the review team that health is an issue not only for healthcare professionals or DHSSPS but across the piece. When talking about prevention, there is an education issue. When talking about rural accessibility, the key issue to emerge in rural areas was transport. It is all well and good to have a service, but if people cannot get to it, it is absolutely useless to them. There seems to be a disjoint between welfare payments, which are the responsibility of the Department for Social Development, and the healthcare sector. We need a much more joined-up approach to ensure that we spend money well and deliver quality outcomes. The users must be at the centre of that approach and must be able to say that this is the type of service that they envisaged and would like.

Mr Durkan:

I have a question on a point that John made about Daisy Hill. We all recognise that changes will be made and that they will not be well received. However, possibly the most important part of the review is how it is communicated to the wider public. As public representatives, we have a role to respond in a mature fashion.

Mr Compton:

Chris Ham has been involved in several similar reviews. If he were here, he would say that one of the key benchmarks of what makes a review successful or not is whether there is unrelenting communication with the public who use the service so that the explanation of why change is taking place is clear and articulate. He strongly emphasised to the review team that the report must say something about communication and have that as one of the key elements of delivery. If we were simply to have a review and outline what we propose to do without continuing that dialogue and debate at a whole set of levels in and with the community, we would run into all sorts of difficulties and problems. There will still be difficulties and problems, but having a continual debate creates a better opportunity to explain what it is we are trying to do.

The Chairperson:

Supplementary to the issue of communication, the key word in that is honesty. I disagree with what Paula said earlier about Whiteabbey Hospital. Although South Tyrone Hospital was the ugliest building in Dungannon, its closure had a devastating effect on people, not only in the town but further out. If people from Carrickmore and Pomeroy were asked whether they were happy travelling to Craigavon for maternity services, for example, they would give a very short answer. The beginning of the end for the South Tyrone Hospital was when maternity services were moved out. We were told that it was for our good and that the outcomes would be much better. In reality, that was not the case for years, because the planning had not been put in place. The decision was made to transfer a highly valued service from Dungannon to Craigavon, and Craigavon could not cope. People do not want to be told that change is for their own good and will improve their outcomes when that is clearly not the case or their experience.

Mr Brady:

I have a further point about communication. Nobody in Newry is against improvement. However, the message that we heard yesterday was that Daisy Hill would close, which raised fears and expectations of a dreadful outcome. In fact, as you confirmed today, nothing of that

nature was even hinted at, so the problem is communication. All of us, including the media, have a responsibility to stand back and think about what we are doing and saying at any given time.

Professor Heenan:
The review team was presented with a key issue in making the case for change. People were concerned that services appeared to be removed or facilities closed without any lead-in period or planning. Changes appeared to be piecemeal rather than strategic, and the removal of one service meant that others became vulnerable. Part of the case for change is saying that, if we are strategically to change the way in which we deliver services, we must do so in a planned, logical, coherent way, and everyone must have bought into that. The value of any change must be clear, and users must be at the centre of that. They must be able to say, "At the end of the day, this will be a better outcome for me and my family" as opposed to, "I read in the paper that X, Y and Z will close next Friday." In the latter scenario, you end up with chaos.

Mr Brady:
Today, people are reading on the front page of my local paper that Daisy Hill is kaput. That is a sensationalist approach.

Mr Compton:
I agree with you, but that is the most powerful argument for a review in the first instance. It is clear that, if we leave the system as is, we will face awkward decisions on the planned transfer of services and changes, and everyone — people who work in the service, people who manage the service and people who use the service — would sense that there was no control of, or order to, how all that was happening.

The issue for me is that, if we do not make the move and change the model, we will, regrettably, face that type of decision and that type of issue. We need to understand the powerful forces at work. Sustainability is a massive issue and wanting it not to exist or the issue to be different will not make it go away — it is here to stay in a big way. We need to understand the implications of that for our services. That does not mean, and the review will not talk about, wholesale closures and all sorts of things that people have tried to get me to say. The mature way of looking at the review is to ask, "What is the need of the population? How do we best organise services to meet the need of that population? What is the best outcome that we can achieve? What is a sensible journey to make the transition from A to B?" That was very much part and parcel of how the review team approached its task, and I am sure that that will be reflected in the final report.

The Chairperson:

I remind members that time is flying, so if your question has already been asked, please do not ask it again.

Mr Dunne:

I welcome the panel, and thank you for your work to date. Staff are, obviously, the biggest resource. As you visited the various hospitals, I am sure that you gathered that there are clear areas of pressure in hospitals, particularly in wards. There is extensive evidence that many wards could not operate without agency staff. The professionalism of those staff has been remarked upon here before. With staff feeling undervalued and morale already low, will they now face further cuts? Will jobs be lost as a result of the review?

Professor Heenan:

When talking to staff, the review team was struck by their wholesale acceptance of the need for change. We have carried out a number of reviews, and people are, quite rightly, cynical about them. People are happy to voice the view that this is another review on top of a previous one that has probably not yet finished. However, those working in the system are also quite clear that there is a need for change. From the perspective of their professional environment, they see that services could be better delivered. They are happy to take the opportunity to voice their opinions and say, "This is how it works at the moment, but would it not be much better if we went in a different direction?" At no public meeting did anyone say, "We think that it works very well as it is, so we should keep it."

The point came through strongly that those who are, by and large, hugely committed to health and social care want to ensure that the system is sustainable and that it creates the best outputs for the users, patients or clients — whatever you want to call them. They are very concerned that the system as currently configured does not measure up.

Mr Dunne:

Will there be job losses as a result of the review?

Mr Compton:

If the direct question is whether the review will recommend a 10% reduction in the X number of thousand people working in health and social care, the answer is that it will not. We are designing the model of care. Of course, any attempt to get to a different model of care and a new way of working means changes in the workforce. However, I do not think that anyone

should expect a recommendation of wholesale job losses in the health and social care system.

Remember that the review started from the premise that we were not asked to do anything with the budget. We were told that there was £4·7 billion before the review and £4·7 billion after the review. The debate is about how we spend that money. We must also be cognisant of the fact that, irrespective of whether a review is ongoing, there are pressures in health and social care, just as there are pressures in education and in any other system. We need to distinguish between those two things, because they exist in parallel. I do not think that the review will outline a doomsday situation for employment.

Ms Lewis:

I thank the panel for its useful presentation. I am sure that the Committee appreciates all the information provided. Older people are first on your list of emerging themes. All of us are hugely concerned about our elderly population, given that it is likely to grow significantly. What emerged from all of your consultations on the elderly? What real and positive impact can be made on that vulnerable group of people in the way of measures and preventative work?

Professor Heenan:

Certainly, the ageing population is one of the pressures on the system. However, as a review team, we want to start by saying that an ageing population is cause for celebration. We are living longer — that is not doom and gloom or a time bomb. We should celebrate the fact that we are, by and large, healthier, able to live independently and living longer. The difficulty is that older people reported —

Mr Gardiner:

Senior citizens.

Professor Heenan:

OK, senior citizens say that they want to be able to live independently for as long as possible. The crux of the issue is how we ensure that services are delivered when, how and where people want them. To what degree can people have some control? If we take home help, for example, individuals say, "Someone comes to my house at 4.00 pm and spends 15 minutes with me." That is not a service: one person may come one day and another person the next. That disjoint in the system makes people feel that they do not get a quality service. It is important to say that we value the fact that people want to remain independent. We must ensure, therefore, that services are delivered to allow people to live independently for as long

as possible.

Mr Compton:

The profound message from our older population is that they want us to enable them to live in their homes for as long as possible. When unable to live at home, they want to live somewhere that is a local proxy to their home. Another strong message from individuals and families is that they want greater control over how their services are organised. They recognise the difficulties and acknowledge the issue that, although the vast majority of people behave responsibly, occasionally, someone might not behave as well. We must ensure that, if money is given to people, it is done in the right way.

People talked to us about whether there should be an advocacy service for individuals who receive community care. An advocate would be an independent person acting on an individual's behalf to ensure that he or she is best placed. When we talked to the Human Rights Commission, its position on that was clear. Advocacy is not about shouting louder; it is about providing informed advice, guidance and support. That was influential in the messages that came across to the review team.

The clear issues in treating our older population are more personal control and a greater ability to remain at home, which means organising services, and a stronger emphasis on care. It is the care issues that people get distressed about: the isolation, the poor transport and, perhaps, malnutrition. All those issues will present themselves in the health system when someone is ill, and, within a number of months, there will be a slow and inexorable decline from their managing quite well to living in an institutional setting. People want us to do something to stop that, to give them greater control and to give their communities a greater opportunity to work to provide preventative support. They also want us to give them greater diversity, because the answer to the question of what makes an individual's life work, which is essentially what this is about, is highly personal. Even two people with broadly the same level of disability may give fundamentally different answers to that question. There is a strong sense that people want the service to be different and to feel different.

Professor Heenan:

It is also worth stressing that, although people want to live independently, social isolation is a huge issue. People want to live independently, but they do not want to go 24 hours without seeing another person. Their homes almost become prisons, for want of a better word, because they have no visitors and no social engagement.

We also had examples from rural communities. There, small amounts of money can allow communities to help themselves, which is what they want to do. Older people organise activities for other older people. They organise very interesting activities that span the generations. They say, for example, that, "Individuals are here to teach us about IT. We are here to talk about the history of the area." We should promote such very useful community projects as good practice. They do not cost a huge amount of money, but such projects are huge issues in mental health, well-being and social engagement. The review team will, perhaps, be saying that they could be models of good practice.

Mr McCallister:
Thank you for your presentation. Was the consultation process good at getting out the message about some of the challenges that health and social care face collectively? Did it interact with people? Did it listen to people's concerns and present the challenges that we face in delivering services? Has the process been useful to you?

Mr Compton:
The process has been enormously constructive. Had you asked me before the process started what I thought might happen, I would have said that we would talk mostly about hospitals because they exert a gravitational pull. However, that was not the case. People have been enormously realistic about the fact that we have a good service. Some of the survey material reinforces that and shows that people's perceptions of the services that they receive are very positive, and that will be in the review. There is a realism that something different needs to happen.

We had what might be called difficult debates and exchanges about changes to services or services moving from one area to another. We presented the logic of the argument for change and the kickback on the other side, which led to a constructive way of reflecting on where we are. It has been, in my view, a good exercise.

Professor Heenan:
The exercise was fairly open as well. We were pleased with the public meetings. As you know, it is difficult to get the public to engage in such meetings: they are too cynical, busy or apathetic. People are aware, however, that health and social care affects everyone, and they want to know about it. The key issue to emerge was that people value their services and, by and large, are very positive about them. The NHS has been described as the religion in Northern Ireland, and, in many ways, that came through.

We had all sorts of interaction through public meetings and e-mails. Perhaps the most interesting evidence that I was sent was ‘My Stay in Daisy Hill Hospital’ by Henry McGrath. If you have not heard of that, I highly recommend it. People had stories to tell in their own way, but they had no issue with getting in contact with the review team, asking for a meeting or wanting their stories to be told. In that sense, the engagement was extremely positive.

Mr McCallister:
One of the biggest challenges, as touched on earlier, is the fear that when we change something, we take away the service, and its replacement never appears. One or two years down the road, the local community feels that it was almost duped into that situation.

Professor Heenan:
That feeling was voiced very strongly. Individuals said: “We might accept that you say that these services could be delivered in a better way. However, our fear is that, once something is removed, we cannot follow the money trail, and we will not be able to say that you promised us X, Y and Z.” They fear being told that, “We have had a spending review. I am sorry, but we no longer have the money for the replacement services.”

The Chairperson:
The argument is that people have managed without in the meantime so do not really need it.

Professor Heenan:
People want to be assured, and they are, quite rightly, cynical. When something is removed, who is to say when its replacement will come? The review team is very aware of those fears. It was mentioned earlier that the key issue is communication. People should be fully aware of what is going on, and they must have bought into the whole process. I absolutely agree that there is a huge fear that, once something is removed, it has gone for ever.

Mr McCallister:
I dare say that each and every one of us, as elected members, hears people expressing that fear.

Let me cite some of your figures and emerging themes: in GB, 5% of patients use 50% of the resources. That is a pretty shocking statistic. To make the necessary sea change in that ratio will require something pretty dramatic.
I have always supported the Public Health Agency moving more towards a proactive approach in health. You talked about looking at mental health and how we need to go further

and promote flourishing mental health in our society and good physical and mental health across the population. It is going to be enormously challenging to change a statistic such as that, even over a five-year period.

Mr Compton:

I do not think that the 5% and the 50% will change. I think that what will change is what the 50% is spent on; that is the core issue. Let us look at enabling people to remain at home as they become senior citizens and older and the difficulties that sometimes emerge for that group of people in such a situation. At the moment, we have a primary care system and a hospital system, and we do not have a lot in between. We have spectacular examples of things that work very well in between the two. However, we did not hear anyone tell us that some people arrived in hospital because it was the only place in which the risks associated with their condition, circumstances and age could be managed. Was it the right place? Probably not.

The issue is the need to manage that differently. Wards in the community are needed, and we need to be able to bring that care to a person's home. If that is done, the nature of where the 50% is currently spent changes. The magic trick, of course, is to get the money to move from one place to the other. That is why the review team is actively considering whether it should incorporate that sort of target arrangement — to reassure the public. We could tell the public that if we are going to make a change here, it will lead to a particular pattern of expenditure. It will, therefore, be like a contract with the public: we said one thing, and we are making the replacement; the public can judge where we are going with that.

Mr McCallister:

John, you spoke about reducing the amount spent on hospitals from 42% to 38%, and whatever millions of pounds that equates to. The contract would be that that stays.

Mr Compton:

Yes, because, all the way through, the issue has been that we have £4·7 billion before the review, and we will have £4·7 billion after the review.

Mr McCallister:

Do you see fundamental changes at the point at which we would access our health service and the pathway through the system?

Mr Compton:

A number of doctors at general practitioner level and consultant level told us that, for the sake of a 15-minute conversation with each other, they could tell if people had spent five days in hospital. Whatever system we have, that is not right. We have to get to a system in which there is greater engagement between doctor and doctor in that regard, and with other professions. It is not just about doctor to doctor. That is what I mean about the reorganisation of a service and a model of care. If it starts from the individual perspective and how that individual engages with the system, how is the support organised when the system decides what support that individual needs? It could be organised around a number of principles, one of which is enabling people to stay at home, because most people want to stay at home. If people have to go to any sort of facility, whether an inpatient psychiatric unit or an inpatient surgical unit, for instance, they go for a purpose and for an outcome — a better outcome. That has to be the model of care. How do you know it is better? You know that it is better because you look at the evidence in front of you and ask what is the best way to manage that condition and how does it work better. If we organise it that way, the individual will have a better experience and a better outcome. That is where the issue has been very substantially quality-driven.

Money is always an issue, and the press and others want to rush to ask what facilities are going to be closed and how much it is going to cost. People go straight there, but that is not the issue. It is about quality of outcome and a better understanding of the quality of outcome. We will then have a debate about how much of that we can afford. To start at the other place is absolutely the wrong way round.

The Chairperson:

I want to deal with that issue, if I may, John. The presumption is that because we spend £4·7 billion now, we will spend that amount after the review. The fact is that, in the current climate, we might not always have £4·7 billion to spend. We have to be realistic about that. I know that you are talking about services following that and finding a better way to do it. However, I frequently see examples throughout the Department of when a decision is made to remove something without recognising that doing so means that it will cost more to do something else and the two budgets do not tie up. Therefore, with regard to community meals, criteria changes, malnourishment, and so on, how much does it cost for GPs to prescribe supplements to try to rectify the balance? How much is the cost of a hip operation versus the cost to ensure that people get medicine that will prevent them from having that operation? The matter is not just about budgets and taking money out of one pot and putting it into another; it is about outcomes.

The Assembly will be debating the issue of osteoporosis and how it is dealt with in the future because its outcomes are horrendous. If someone who is over 75 years of age breaks a hip, that person has a one in 10 chance of seeing the anniversary of that break. If that person lives in a nursing home, there is a four in 10 chance. That is horrendous. It costs far less to put people on medication that will prevent them from breaking a hip than it does for the operation to fix it. Dr George O'Neill, who is a GP and the chairperson of a local commissioning group, told us how something as simple as a pair of slippers that fit properly could prevent someone from falling and breaking a hip.

Mr McCallister:
Or something as simple as cutting one's toenails.

The Chairperson:
Yes; podiatry and all of that. Therefore, there is a relationship between different elements of the departmental budget. People talk about joined-up government. That is great. I wish there were more of it. Sometimes, I wish there was more joined-upness in one Department.

Mr Compton:
Not for one minute would I say that we have not got things to do in our own house. Clearly, we do. What you talk about is pathways and proper pathways of care, and how we handle a pathway of care so that we do not ignore a matter that appears minor but is very important. Suddenly, it becomes a major problem. That is the issue. Some professionals will use the word "integration". What they actually mean is working sensibly together and talking to one another, so that when someone is managing those services, they are aware of all those aspects.

We all know of situations in which someone who lives alone does not feed himself or herself properly or have much contact or transport. It is inevitable that that person will become ill, be seen by a GP and find himself or herself in hospital. Given that we know all of that, we should intervene on the quality outcome evidence that we have and do something about it. We should get communities more involved. They say that they want to be more involved. That service is not expensive. The expensive service is not up here; it is down there. The message for us has clearly been to get that involvement and to make it happen in a different way.

Professor Heenan:
We have had good examples of communities wanting to help themselves. Senior citizens are

very clear that they do not want to be depicted as a drain, needy and dependent. They are vibrant people who have had very little contact with services and want to remain that way. However, they still want the reassurance that when services are required, those services will be available and that, when they are admitted into hospital for some sort of procedure, they will be viewed in a holistic way. Therefore, if an individual goes into hospital for cataract surgery, for example, and the surgeon says that the operation has been a fantastic success, that individual will not simply go home, have no support and have a fall that has a serious negative outcome. We have to look at the whole picture. People who work in health and social care have been very clear in saying that although we talk the talk about integration and, on paper, we have an integrated system, the fact is that many professionals work in their own silos. They do not have time to raise their heads to see what is going on around them and to look at the bigger picture. We have to ensure that the system enables people to work as multidisciplinary teams.

Ms Boyle:

I will be brief. Thank you for your overview of the situation to date. I will go back to Mark's earlier question about co-operation between the North and the South. Although, at present, it is not exceptionally pertinent to the review, equally important to the question is the current budget in the South, where they are looking at cuts to red-eye, out-of-hours and NoWDOC services, particularly in border areas. I come from Strabane, which is right on the border, and I know that we have co-operation in fire and ambulance services. A number of people live in rural border areas there, and I wonder whether a conversation is happening about how best to utilise our GPs in those areas, particularly when it comes to out-of-hours and red-eye services.

Mr Compton:

The conversation has not been restricted to any particular aspect. We have been keen to try to establish whether we can get a more structured conversation about a whole range of matters. Quite a lot of things are going on in local areas: there is Cooperation and Working Together (CAWT) and cross-border projects. It has struck the review team that with regard to service resilience and sustainability, at the big level of 1·8 million people, some tertiary issues can be picked on which it would be common sense to work together, such as cancer work in Derry. There are lots of local things that are geographically pertinent. We think that it would be better if there were something more structured. We are reflecting on whether it would be helpful to include that in the report. Any conversations that we have had with our colleagues in the other jurisdiction have been very open-ended; they have not been narrow or restricted, nor have any subjects been kept off the agenda. It has been more about getting a mechanism to enable us to have those sorts of conversations and the authority and the permission for local

people to have those conversations in a sensible way.

Ms Boyle:

I have one more brief point. I know that you cannot disclose an awful lot, but I want to ask about the new dental contract. You have obviously been having a conversation with dentists and the commissioning groups. Can you elaborate on that a wee bit more?

Mr Compton:

The dental contract is out for consultation at the moment. I do not think that anyone has found that that contract, as it is currently presented, should not be developed. That is outside the review, but we are paying attention to it. I do not think that there will be any remarkable changes in that. We had a further conversation about how oral surgery is provided in local areas and whether it is better to provide that locally or in a hospital environment. There are plus and minus arguments. The review will take professional advice on that, but the determining principle is to try to keep that provision as close to people's homes as we can. We want those services to be as close as they can for individuals.

The Chairperson:

I have a few questions, John. I recognise the time, so yes or no answers will do me.

Mr Compton:

OK.

Mr Dunne:

That is a change.

Mr Compton:

Yes or no answers are dangerous, now. *[Laughter.]*

The Chairperson:

You already said yes.

Will human papillomavirus (HPV) testing, screening, early intervention and better outcomes be discussed in the review?

Mr Compton:

The review will not get down to the detail of every single test that is done in that way, but the

idea of using prevention will be part of it.

The Chairperson:

I was disappointed that we did not have more targets in the draft Programme for Government, which is very light on actual targets and on where we are going. We have been lobbied on the issue of self-referral for services such as physiotherapy. If you are determined to challenge the status quo and find a new way of doing things, that could help to reduce GP times and all the rest of it. Will that level of detail be in the review?

Mr Compton:

There is a level of detail that deals with how we organise primary care services, which includes physiotherapy. That will be reflected in the review. I am not saying that it will about physiotherapy, but we will look at how to handle that differently. It will break traditional patterns, if you want to refer to it in that way.

The Chairperson:

So words such as self-referral will be in the review somewhere?

Mr Compton:

I am not prepared to say that. *[Laughter.]*

Professor Heenan:

The issue of access will be there. That is probably where that issue will be discussed.

The Chairperson:

It is about how services are accessed.

Professor Heenan:

It is also about gatekeepers.

Mr Compton:

We hear what you say.

The Chairperson:

At the moment, 19,000 people suffer from dementia. That figure will be 60,000 by 2051. That is a serious challenge.

Mr Compton:

It is a very clear issue for us about how we respond to that, where we respond to it and the various levels of response for individuals. If we leave our current model of care, it will really struggle to deal with the complexities of that issue. When you talk to families who are working with that, it is clearly a real concern. Many families are unbelievably caring but fell very isolated. A lot of pressure has been put to us about handling respite services, particularly in that area. Those issues will be referred to.

The Chairperson:

I was disappointed that I did not hear more of that because it will probably be one of our biggest challenges. If we have the right building blocks now, we can help to prepare our community, and we can also try to alleviate the worst ravages of Alzheimer's disease.

Professor Heenan:

It is interesting that the public are saying that they want to undertake that caring where and when possible. They are not trying to divest themselves of the responsibility. They want acknowledgement that they are doing that work, and they want support.

The Chairperson:

How many times did you hear from people that they had worked all their lives and have never asked for anything, and now, when they need help, they cannot get it?

Mr Compton:

A lot.

The Chairperson:

I bet that you did, because we get it all the time.

I am concerned about the Mater Hospital issue, which Jim brought up earlier. I did not get into the whys and wherefores of the decision; I felt that it was undermining the group. The leak came out when we were in the middle of a consultation in which the Patient and Client Council was involved. You have robustly —

Mr Compton:

We had nothing to do with that.

The Chairperson:

—confirmed today that you were not responsible, but we will see what the report says when it comes out.

Mr Compton:

That is a yes answer.

The Chairperson:

Spending to save is difficult for the current Health Minister because the result of bold decisions may not be seen for 10, 15 or 20 years. However, we need those bold decisions. Prevention is the key thing —

Mr Compton:

It is a very clear theme.

The Chairperson:

— to keeping people well.

Professor Heenan:

We have looked at international evidence. Other people have said that they have huge difficulties in particular areas, but they have grasped the nettle and said that they have to do something about it and that the time for talking is over. We need to decide what we are going to do to address the issue and to ensure that prevention is the name of the game.

The Chairperson:

A week or two ago at the Peninsula Healthy Living Centre, departmental officials briefed the Committee on breastfeeding. As well as all the other benefits, it can help to reduce obesity rates in children. However, there is no legislation. We spend about £250,000 a year on a breastfeeding strategy that is clearly not working. Despite the World Health Organization's recommendations, 1% of babies are breastfed at six months. We also need more support for families. We asked the Minister for evidence around Home-Start in relation to early intervention that worked for families and avoided more expensive and much more complicated and difficult interventions later. Those interventions are with you for a lifetime. If people end up in the care system, even for a month or two, it has an effect on them that they will carry for the rest of their days. However, he could not give us any evidence at all. It is very unfortunate that, when we are reviewing the services that we provide, we could not get an answer about the effectiveness of that.

Mr Compton:

We know from the evidence that the care system does not deliver, and we know the consequences of the care system. Therefore, it is very important for us to try to avoid the care system if we can for any individual. That is why I talked during the presentation about using the generic phrase "Head Start". From pregnancy to five, there needs to be a much more robust prevention and development programme. Ultimately, investment at that stage of a youngster's life changes the potential outcomes for that youngster and his or her family. A very profound and impassioned lobby told us to look at the ability of children's services to deliver something very differently in that way. It was a very strong message.

The Chairperson:

Suzanne Zeedyk gave a presentation in Armagh a couple of weeks ago and stated that, if a child does not get the proper stimulation and intervention in its first days and weeks, that serious neglect means that that child will never ever catch up. That has implications throughout society, not just for the health system and mental health but for the justice system and the education system.

Mr Compton:

We are very aware of that, and there will be things in the review about that.

Professor Heenan:

Early intervention will be a theme.

The Chairperson:

Will the review talk about a funding arrangement, or will that follow?

Mr Compton:

I will let you read the review, and you will see what it says.

The Chairperson:

I am dying to read the review. Give me a copy, and I will sit up all night and read it. *[Laughter.]*

Mr McCarthy:

Am I correct in saying that you have chosen next Wednesday to hand over the report?

Mr Compton:

Next Wednesday is 30 November. Production and so on may slip by a day or two after that but no more.

Mr McCarthy:

Could you not slip it to this side of next Wednesday? The House sits on Mondays and Tuesdays, and that would give the Minister the opportunity to address the Assembly on 28 or 29 November.

Mr Compton:

That is for the Minister to decide.

Mr McCarthy:

It is a suggestion. The longer you hold the report, the more rumours there will be.

The Chairperson:

I imagine that the Minister will want time to read it himself, Kieran.

Mr Compton:

To be fair, it is not unreasonable that he gets a few days to read it.

The Chairperson:

If you want to make it available to us at the same time as the Minister on a completely embargoed basis, we would respect that. Wouldn't we? *[Laughter.]*

Mr Brady:

I just want to reassure Deirdre that Henry McGrath is not my pseudonym.

The Chairperson:

It said age eight, Mickey. Hopefully your writing is better than that. *[Laughter.]* What age was Henry?

Professor Heenan:

He is a raconteur from County Down. I believe that he is in his 80s.

Mr Brady:

Close enough then. *[Laughter.]*

Professor Heenan:

No comment.

Mr McCallister:

It could be Mickey.

The Chairperson:

I do not think that anything has been more anticipated than this report. We look forward to seeing it, and we need sight of it. I am not opposed to change. I am opposed to change for the wrong reasons. I recognised the Department of Agriculture and Rural Development's anti-poverty work, for example, in which we identified rural transport, fuel poverty in rural areas, rural childcare and a whole lot of things. Some of my best events were in places such as Boa talking to senior citizens about the improvement that access to transport made to their lives and mental health.

I cannot overemphasise the importance of everything working together. Unfortunately, there are still far too many silos. We are all frustrated. Every day, we bang our heads against whichever silo we happen to be dealing with at the time. We recognise the figures: in primary care, 5% of patients use 50% of resources. That 5% worked a lifetime to have dignity in later years. We still want investment in our older people to help them to continue to be valuable members of our society and not a burden or drain on our resources.

Mr Compton:

That is right. I want to finish by saying that it is not the 5% — it is everyone. As I said earlier, we all have an entry ticket to join that 5%. It is important that the situation is not in any way presented as if there is a troublesome group of people who are causing us all the problems. It is quite the reverse. It is just that we join the 5% at a stage in life. It is important that the rest of society remembers that when they have the discussion.

The Chairperson:

Paula, you asked a very brief supplementary question earlier. I will give you the chance to say one more thing if you want to, although I am not putting you on the spot.

Ms P Bradley:

I have such a sore head now that I can hardly think.

The Chairperson:

These meetings used to go on for six or seven hours. I am trying to keep them as short as I can.

Mr Wells:

Those were the days.

Ms P Bradley:

The good old days, Jim. *[Laughter.]*

The Chairperson:

Thank a million, John, Catherine and Deirdre.

Mr Brady:

Can the group reassure Jim that all this will be sorted out within 18 months before he enters stage left? *[Laughter.]*

Mr McCallister:

I do not mind. As long as we get to blame Jim, it is a good news story.

The Chairperson:

We can always find a way to do that. Thanks a million, everyone.