Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Workforce Planning in the Context of Transforming Your Care: Department of Health, Social Services and Public Safety/Health and Social Care Board

24 June 2015

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 Maeve McLaughlin (Chairperson)
Mr Alex Easton (Deputy Chairperson)
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Paul Givan
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Fearghal McKinney
Mr George Robinson

Witnesses:

Mr Mark Lee	Department of Health, Social Services and Public Safety
Ms Caroline Lee	Department of Health, Social Services and Public Safety
Mrs Heather Stevens	Department of Health, Social Services and Public Safety
Mr Dean Sullivan	Health and Social Care Board

The Chairperson (Ms Maeve McLaughlin): We have with us today Heather Stevens, director of workforce policy and chair of the Department of Health, Social Services and Public Safety's regional workforce planning group; Mr Mark Lee, the Department's director of healthcare transformation; Mr Dean Sullivan, director of commissioning at the Health and Social Care Board (HSCB); and Caroline Lee, the Deputy Chief Nursing Officer in the Department.

Before we start, I want to raise an issue. Officials chose not to provide a new briefing paper for us today. Why was the Committee not given a briefing paper, and why was it notified at such a late stage?

Ms Heather Stevens (Department of Health, Social Services and Public Safety): In that case, Chair, I apologise. We were not under the impression that the Committee had particularly asked for a briefing paper. We had intended, by way of presentation, to give you a brief update on developments since the previous time that we appeared before the Committee. We are happy to follow that up in writing, if that will be helpful.

The Chairperson (Ms Maeve McLaughlin): It will be useful to put it in writing, but we had expected to receive the briefing paper in advance.

Ms Stevens: I will take that on board, Chair. We did not appreciate that. Apologies.

The Chairperson (Ms Maeve McLaughlin): I invite you, Heather, to make the opening remarks, and we will then open up the meeting to questions.

Ms Stevens: Thank you and good afternoon. We are grateful for the opportunity to discuss with you further the issues emerging as a result of your review into workforce planning. With me today are Dean, who has responsibility for commissioning at the HSCB, Caroline, who is the professional lead on nursing and midwifery workforce issues, and Mark, who has policy responsibility in the Department for the broader transformation agenda, including Transforming Your Care (TYC) and primary care policies, such as GPs.

By way of introduction, I will set out some of the positive developments that have taken place since I last appeared before the Committee. First, the regional workforce planning framework has been signed off, and you have received a copy of that. That framework is key to moving forward, as it sets out the respective roles of the Department, of the HSCB and the Public Health Agency (PHA) as commissioners, and of the trusts. In summary, it establishes that it is the Department's responsibility to set the vision; to ensure that a regional approach is taken; to provide regional information and trends; to facilitate capacity building; and to make decisions on the commissioning of pre- and post-registration education and training as a logical conclusion of the workforce planning process. It is the role of the board and the PHA as commissioners to determine and agree the various models of service delivery, including the outworking of TYC; to challenge the trusts or providers to ensure that they have identified their workforce needs to be able to deliver the commissioned services; and then to flag to the Department where intervention on the supply side is needed, recognising that there is a lead time to making an impact on the workforce through training. It is the role of trusts to ensure that they have an appropriate and skilled workforce in place to develop operational workforce plans, to adapt to what is being required and to makes changes to their own workforces as required. That is the framework, and, as I said, it has been signed off.

On the programme of workforce reviews, you will recall that, at our previous appearance, the regional workforce planning group had just approved taking forward a workforce review of domiciliary care. That work is progressing well. A steering group and a project group have been established, drawn from across the relevant stakeholders, including the trade unions, and there is a linkage to the independent sector providers.

Terms of reference and time scales have been agreed, so we are aiming to complete that work by the end of 2015. An initial data-capture analysis has been performed to assess the size of the workforce, the number of contract hours provided, expenditure, and so on. That is very much building on the regional review of domiciliary care led by the board, the purpose of which was to determine the service models for future delivery. That is almost complete.

That future service model is moving away from time-and-task towards an outcome-focused service, which will build in continuous improvement and innovation. It will look at the skills needed, at the training required and at how we can develop attractive career pathways for individuals who want to work in that key area.

The area was selected to enable us to test a programme-of-care approach to workforce planning focused on older people. Our work to date shows that it will do that, as older people make up 80% of the client base.

Last time, I mentioned that a rolling programme of medical specialty reviews was ongoing, led by the PHA. That works continues. Paediatrics was completed in September 2014, and no additional trainees were recommended. General practice was completed, as you know, in October 2014. The initial interim report, which you will have seen, has been confirmed as final, with a recommendation for a phased introduction of a minimum of 15 additional trainees by next year to meet the current ratio of trainees to population in England.

For radiology, radiography and medical physics, workforce data has been completed and submitted to the Department as part of its regional review of imaging services. The aim of that wider review is to produce recommendations on service configuration, skills mix and optimal use of skills to best address future demand, all of which will inform the development of an associated workforce plan.

Shortly to be completed are reviews of occupational medicine, trauma and orthopaedics, and emergency medicine. A further tranche of reviews will encompass geriatric medicine, anaesthetics, intensive care medicine, acute medicine, urology and haematology. In fact, the plan continues from

July to December 2015. Other specialties identified include neurology, opthalmology, psychiatry and dermatology.

You may ask why those are relevant in the context of TYC, but they are, because, for each of the specialties, we have the opportunity to challenge how it is delivered and whether there is a better way. What is the service model that we need to plan for? For example, I mentioned dermatology. Will we need as many consultants and junior doctors in that specialty if, for example, GP federations facilitate cross-referral in practices to GPs who have particular expertise in the area?

In addition to the work on medical specialties, separate work on a general medical workforce review that is focused on informing the number of medical undergraduates is continuing. The regional workforce planning group met on Monday of this week, 22 June, and considered the emerging need for workforce reviews relating to allied health professions, paramedics and the range of dental professionals. They will be scoped and built into our programme of work.

However, we need to be absolutely clear that we will looking at them through both a professional and a programme-of-care approach, informed by the domiciliary care experience, all with a view to progressing and furthering the aims of TYC.

For completeness, I should mention that a comprehensive and robust workforce review of nursing and midwifery has been completed. Work continues on implementing the various phases of normative nursing, which Caroline can expand on, if that will be helpful.

The primary purpose of the raft of workforce reviews has always been to identify where there are projected shortages or potential oversupply in order to inform our decisions on the commissioning of education and training places. However, we have recently been discussing what we can do to address our "leaky bucket" situation, which is how the chief executive of Health Education England (HEE) described the situation whereby the NHS, or Health and Social Care (HSC) in our case, trains people at huge expense only to lose them to other countries. We commissioned some work internally that looked at how other countries incentivise the recruitment and retention of medical staff. The work looked at issues such as work-life balance and the possibility of introducing more downtime between shifts and providing childcare discounts. It looked at work-related incentives; for example, enhanced periods of study leave or extended leave to undertake further training after a period of time, such as five years. It also looked at staff recognition incentives, such as mentoring or the awarding of extra leave for a completed project; regional incentives, such as bonding schemes, whereby fees are paid off for every year worked in the health service; and recruit-and-retain initiatives, including finding ways in which to support spouses or partners to find work, childcare or schools and strengthening urban and rural links to minimise rural isolation. We now need to consider those ideas and decide what we can apply or adapt for use here. Of course, although our initial focus has been on the hard-to-fill medical posts, there is nothing to stop us applying the same principles to any and all disciplines.

A further development has been in the area of skills mix. You may be aware that, elsewhere in the UK, the role of physician associate (PA) has been piloted. That has drawn on experiences in the US and has been found to be a very valuable alterative to middle-grade doctors in some areas of secondary care, and a valuable source of support in primary care as well. PAs are generally individuals with, for example, a biomedical science degree. Therefore, with a further two-year postgraduate medically orientated training programme, they are equipped to work along a medical model and under medical supervision. We have liaised with colleagues in the Belfast Trust and the Western Trust, and we are pleased that the Belfast Trust will utilise some resources that would otherwise have been used to pay for locum cover to pilot a small number of PAs in the emergency department setting. We have also discussed with the Northern Ireland General Practitioners Committee (NIGPC) how we can test the added value of such a role in the primary care setting in Northern Ireland to help address the workforce issues that have been flagged up by the GP workforce review. Alongside that, we are seeking to expand the number of advanced nurse practitioners, as a further opportunity for those who want to develop their skills and expertise, while at the same time helping to address areas that have been traditionally hard to fill.

Finally, I want to mention specifically recent developments with GPs. Back in March, no decisions had been made on the 2015-16 Budget, and, in fact, we are still in a situation in which budgets are not confirmed. However, a bid for the full 15 places recommended in the workforce review has been submitted as part of the June monitoring round. The GP workforce review also made a series of other recommendations on retaining our workforce, and the GP package that the previous Minister, Jim Wells, announced on 1 April takes those forward. Therefore, as well as providing additional funding for out-of-hours GP services, the package recognised the need to invest in the skills mix in primary

care, with £1·2 million for trialling different approaches in primary care, including increasing the provision of GP-led phlebotomy services. The package also included up to £300,000 to recruit and retain more GPs in Northern Ireland.

I hope that that has given the Committee some sense of the range of the work that is and has been happening in the area of workforce planning. We have a framework and a plan, and we are taking those forward. In taking those forward, we will certainly consider the structures that we have for workforce planning in order to get them right.

I hope that that has been helpful. We are happy to expand on points or to answer any questions that you may have.

The Chairperson (Ms Maeve McLaughlin): Thank you, Heather. To start with, I want to clarify something. Who leads on workforce planning?

Ms Stevens: Workforce planning is led on a regional basis by the Department through the regional workforce planning group. However, it is also undertaken at a local level.

The Chairperson (Ms Maeve McLaughlin): It is the Department that ultimately leads on it.

Ms Stevens: The Department leads on regional workforce planning.

The Chairperson (Ms Maeve McLaughlin): To be clear, the original strategic implementation plan for TYC stated:

"The HSBC will lead on the TYC transformation programme."

It went on to state that it recognises:

"that the responsibility for workforce planning rests with the DHSSPS".

Is that an oversight or flaw?

Ms Stevens: I will let Dean come in as well, but my sense is that it is not, because the board is responsible for service model delivery and development, and that is the space that TYC is in.

The Chairperson (Ms Maeve McLaughlin): Do you agree, Dean?

Mr Dean Sullivan (Health and Social Care Board): Yes, I do.

The Chairperson (Ms Maeve McLaughlin): What about the level of importance that is given to workforce planning? Is its profile in the Department high enough?

Ms Stevens: It is certainly a key priority for the Department, and I think that the work that has been done to move workforce planning along is indicative of its current level of priority. We are taking forward work on a number of fronts. We are not only taking forward the workforce reviews that I mentioned but looking at helping trusts do more interesting things to recruit and retain staff. We are more heavily involved in workforce planning than we have been.

The Chairperson (Ms Maeve McLaughlin): A lot of the commentary that we have received in evidence to date has talked about being three-plus years into the process and how workforce planning, in its entirety, is only being activated now. Do you accept that?

Ms Stevens: I agree that there was a hiatus while work needed to be done, as a result of Skills for Health coming in, on a diagnostic report, which stated that there was not clarity around roles and responsibilities. That took some time to work through. However, we now have a framework that sets out those roles and responsibilities very clearly. It is indicative of the ability to move at pace since we agreed those roles and responsibilities that we have been able to take forward the work quite quickly. Therefore, that time was well invested. In the meantime, at that very operational level, the trusts, which I know support the position, have continued to plan their workforces on a regular basis to deliver the services that are commissioned by the board and the PHA. That work does not stop.

The Chairperson (Ms Maeve McLaughlin): Ultimately, the Skills for Health report helped initiate some of that work around roles and responsibilities.

Ms Stevens: It certainly did. It identified that as a clear need, and we have responded to meet that need.

The Chairperson (Ms Maeve McLaughlin): OK. Does the process of commissioning require the board and the PHA to produce a workforce plan?

Mr Sullivan: It is hard to respond to that in the abstract. I will talk about a specific service and a number of processes that are ongoing at the moment. In something like the Transforming Cancer Follow-up (TCFU) programme, for example, the board and the PHA, working with the Department and in partnership with Macmillan, have fundamentally changed the way in which women with breast cancer are followed up after treatment. Previously, following that treatment, ladies would have had a number of review appointments with a surgeon and an oncologist, regardless of the added value of some of those appointments, and potentially, for five years and more, they would have continued to have those review appointments. The arrangement that is now in place across Northern Ireland is that only by exception do women, following breast surgery treatment, have a series of review appointments with an oncologist. The typical position now is that they are allowed to get on with their life and to focus on their well-being. They are supported in that regard by clinical nurse-specialists, third-sector organisations, and so on; by having the right information; and by support groups. If we take that as a snapshot example, what it means is that, compared with what would have been the case, the pressure on oncology staff — on consultant oncologists — is lower than it would otherwise have been. The number of consultant oncologists is lower than it would otherwise have been, while the need for clinical nurse specialists, and other support staff to work alongside them, is greater than it would have otherwise been. Ultimately, that will feed through into the sort of work that Heather is describing when we are thinking about the consultant oncologist workforce and the nursing workforce, and, specifically within that, the clinical nurse specialist workforce.

Oncology is a factor in that, but it is a relatively small one. There are much bigger pressures driving the number of consultant oncologists that we need in Northern Ireland, such as the number of patients with cancer in Northern Ireland and the development of the second radiotherapy centre in Derry. There are several other pressures, and they are all far bigger drivers of change. Even though that is a fundamentally different service model, in relative terms, it has an impact that is small in scale compared with that of growing population need and demand, and the impact that that has. The work that Heather described so comprehensively earlier is drawing on all of those. It is drawing on the impact of demographic pressures, the impact of different approaches to providing care within a profession and the different approaches to providing care across professions.

The Chairperson (Ms Maeve McLaughlin): Therefore, there is no requirement for the board or the PHA to produce an annual workforce plan.

Mr Sullivan: I do not believe that there is, Chair.

The Chairperson (Ms Maeve McLaughlin): Is that something that the Department may consider or has considered?

Ms Stevens: It is an interesting idea. With the extent to which the work is developing, and as service models are changing all the time, an annual workforce plan would be just a snapshot of what is required at that particular time. Again, it is questionable whether the work to invest in describing what is happening is worth it.

The Chairperson (Ms Maeve McLaughlin): What time frame is the Department working towards for workforce planning? Is it a three-year plan, a five-year plan or a 20-year plan?

Ms Stevens: It is a rolling programme. We identify the issues to be reviewed and explored. Any of the workforce reviews that we do, such as that on domiciliary care, will have a five-year horizon. We look to a five-year plan, because we think that one for any longer than that is looking too far in advance to be able to plan for. What might the demography and the situation at the time be? We therefore have a five-year horizon for those individual workforce plans, and that will constantly move on a rolling programme.

The Chairperson (Ms Maeve McLaughlin): You are ultimately saying that any longer than five years will not be feasible.

Ms Stevens: I think that it is not feasible. Five years tends to be the optimum period in which to create the opportunity for lead-in times and for training to be able to impact on the workforce. It does need to be done over that horizon.

The Chairperson (Ms Maeve McLaughlin): Can you clarify who is responsible for delivering the new service models?

Ms Stevens: That is very much the responsibility of the board and the PHA in discussion with the trusts.

The Chairperson (Ms Maeve McLaughlin): There is much debate around the current status of Transforming Your Care. Is that still advancing and driving the workforce planning agenda?

Ms Stevens: It is certainly the driver. That is the context in which we are operating.

The Chairperson (Ms Maeve McLaughlin): It is absolutely still the driver. There has been no shift.

Ms Stevens: No. We are working to implement TYC, and the shift-left agenda.

Mr McKinney: Why did you use the word "context" and not "plan"?

Ms Stevens: Sorry?

Mr McKinney: You said that the TYC is the context.

Ms Stevens: It is. It is the policy driver. Its whole ethos and its objectives are fundamentally the foundation on which we build our work. I could say "plan".

Mr McKinney: It is just that we have recently had it described as a "philosophy". The Committee would worry that it is losing some of the practical, planned, targeted nature that it set out with.

Ms Stevens: Mark, do you want to comment on that?

Mr Mark Lee (Department of Health, Social Services and Public Safety): The 2011 TYC document is not a plan per se; rather, it is a set of proposals and a description of a service model to move to. I guess that the things that follow that, such as the strategic implementation plan that the Chair referred to, are the plans. TYC itself is described as a service model. It talks about things that we should seek to achieve. The detailed plans follow on from that, so TYC is delivered through the commissioning plan and through other plans that exist across the system.

The Chairperson (Ms Maeve McLaughlin): How far advanced is the Department with the service models? How many are in place, how many have to be implemented and who is monitoring them?

Ms Stevens: Again, that is for the board and the PHA to lead on.

Mr Sullivan: The way in which you framed the question, Chair, is interesting. I am not sure that it has a beginning and an end. It is a live issue all the time. What Heather was alluding to when she described TYC as a context was a way of thinking. As recently as this morning, Mark and I were at a meeting on outpatient reform. Providing outpatient services closer to a patient's home is referenced in Transforming Your Care but not in any huge detail. This morning, we were talking about whether there were opportunities whereby, rather than being referred to secondary care to see a consultant, a patient could be cared for safely in a primary care setting by the GP operating in a different way, perhaps with different support from GP colleagues. Are there circumstances in which a patient can avoid being sent into secondary care, potentially by a GP working in partnership with secondary care colleagues and being able to refer for advice, and so on, or having access to a specialist opinion in some way? Is there potential for primary care colleagues to refer patients to secondary care without

the need for an outpatient appointment and directly list them for a diagnostic test or surgical treatment? All of that was discussed this morning. All of that will result in different service models, but they are unique to individual specialties. The answer in dermatology will be different from the answer in ear, nose and throat (ENT), which will be different from the answer in orthopaedics. It is all the time. It is not the case that we have to produce 10 service models, and, when we produce those, the job is done. It is a way of thinking. It is a context for the way in which we think. It is about trying to work from a patient's point of view.

The Transforming Cancer Follow-up example that I mentioned earlier is exactly the same thing. Going up to see the hospital doctor every six months might have a negative impact on a patient — the worry, and so on. If there was no value in that process, from the patient's perspective, why would we continue to do it? The service model has been designed and implemented and is now in place. We are at the leading edge of that across the UK. No one else in the UK is close to how far we have progressed that TCFU model.

There is never an end to this. There will always be a new service to look at and a different opportunity in an existing service. Therefore, I do not think that we can say, "That is 10 done. Closed off". It is a live, open-ended position.

The Chairperson (Ms Maeve McLaughlin): It is an area in which you need to have your service models in line with your vision. At what point do we get there?

Mr Sullivan: I do not think that we ever get there, Chair. That is exactly the point that I am making. The day and hour that we decide that we have got there, we have missed something. It is about continuously looking at the service and about continuing to look at opportunities to improve the service to make it more responsive to patients and more cost-effective.

The Chairperson (Ms Maeve McLaughlin): Can we say, "We need x number of service plans"?

Mr Sullivan: No, I do not think so.

The Chairperson (Ms Maeve McLaughlin): We cannot say that. You do not have a sense of how many new service delivery plans will be needed.

Mr Sullivan: Take the example that what Mark and I were talking about this morning around outpatient reform. It was quite an effort to begin even to scope out where we might focus our attention. Through that process, we will probably focus on five or six things at a regional level, but there will be another five or six after that, and another five or six after that, and further iterations within each of those as to where we go. Therefore, I do not think you can put a hard number on it. It is not a case of saying, "There are 26, and when we have implemented 26, the job is done", because something else will come along that provides an opportunity and a new way of looking at a service, perhaps something that was reformed a year ago.

The Chairperson (Ms Maeve McLaughlin): If it is so much of an evolving process — again, the monitoring is critical — who oversees it all? Who makes sure that the processes are evolving and being actioned? I assumed that a service plan requires a start date, an end date and an estimated cost.

Mr Sullivan: Individual bits of the service will have that. The process that I mentioned from this morning is a subset of the Transforming Your Care implementation agenda, because it is a key regional programme. That process reports through a formal infrastructure. Within that process, there will be a defined timeline by which each of the reform projects that is taken forward will be planned, rolled out within a local commissioning group (LCG) or trust area, and, if successful, rolled out across the region. Therefore, there are hard timelines for elements within that. A fraction of the reforms that are being taken forward on any day are formally under the Transforming Your Care banner.Again, the cancer example that I gave, and many other examples that I could give, are just work that is being taken forward as part of routine work in trusts and primary care working alongside commissioner colleagues and, as appropriate, where there are policy implications, the Department.

The Chairperson (Ms Maeve McLaughlin): I go back to the point that there were very clear directions given in TYC that would require workforce planning models. I use the example of the five to seven hospital networks, which was a target agreed. So, you either do that or you do not.

Mr Sullivan: The way that you get at that though is more from the end that Heather described, which is that you focus on areas of greatest workforce challenge. I think that Heather mentioned radiology. The Department has initiated a regional radiology review. As part of that review, we are looking at where the demographic changes are going, the role of radiologists, the role of interventional radiologists and the role of radiographers and support staff in all of that. Again, that is a process with a defined start date and end date, and, out of that process will come the number of different staff groups that will be required.

The complicating factor in that is what is assumed around staff turnover, staff retirements and so on, and it is all done within a framework where finances, as we around this table know and have rehearsed before, are very tight. So, we do not have the luxury of training a surplus of staff. Indeed, it is quite the reverse; we are struggling even to train the bare minimum of staff that we know we need in any circumstance.

The Chairperson (Ms Maeve McLaughlin): With regard to oversight, is the Department saying that you can reasonably and realistically monitor the board in relation to the implementation of TYC or workforce planning to do TYC?

Ms Stevens: We have a process, through the workforce reviews, of examining each of the areas in the work of the regional workforce planning group and making sure that TYC has been taken into account when looking at the service delivery model that we are workforce planning for. So, that is a scrutiny role that we can do and a challenge function that we will exercise.

The Chairperson (Ms Maeve McLaughlin): Do you envisage at some point that the workforce planning group will produce an overarching plan, which will be one plan with requirements and timetables?

Ms Stevens: Like an overarching workforce plan or workforce strategy document? We clearly have a plan that we are working to. If you are asking whether we can pull those strands together and create a document that sets out what we are doing and shows the programme, we can do that. We are doing it, and our Minister has given us a clear steer that he wants to see action as opposed to documents describing what we will do. So, we are focusing on doing the work, but we could pull it all together.

The Chairperson (Ms Maeve McLaughlin): But it is not something that you are actively working on at the minute, is it?

Ms Stevens: No, we are progressing the work and taking forward the different strands that a document would comprise, and we want to see progress in relation to those.

The Chairperson (Ms Maeve McLaughlin): OK. Thank you for that. A number of members have indicated that they want to ask questions.

Mr McKinney: I think that it should be put on record that a lot of time and momentum has been lost, given the original plan that we referred to was for TYC to happen in 2011 and given that the headline in it was specifically and clearly about a growing older population and pointed in the direction of doing some of the work that we are now talking about. It is a no-brainer. I will reflect on a number of concerns that we have been hearing through the review, particularly around the silo mentality, a lack of a holistic approach and failure to have gathered sufficient data for the decisions? Heather, you touched earlier on the scoping exercise. Will you give us a bit more on the workforce review in respect of domiciliary care?

Ms Stevens: OK. That work kicked off after it was approved back in March. What we have is a project group pulling the work together, overseen by a steering group. In that steering group, we have, for example, requested trade union membership and independent sector providers —

Mr McKinney: You have requested them, but are they on the group and are they participating?

Ms Stevens: We have asked for the nominees. We are waiting to get confirmation. They asked for two places. That is fine; we are going to get the nominations in.

Mr McKinney: How much work has been done ahead of that, or is their presence required for the work to be started?

Ms Stevens: Work has started on gathering the information. That, literally, is just a matter of gathering the information that already exists from the different sources. That work is being pulled together at the moment. It has not been analysed, so those people will be very much at the table when that work is pulled together and there is something to discuss. We have taken forward what I describe as the very practical initial pieces of work that have to be done for proper discussions to be had with all the stakeholders. That is happening, and we have drawn —

Mr McKinney: Just to clear up that issue, some people, when they are brought along later to a meeting, feel that the meeting has already been sorted out and packed; I do not mean numbers but the terms of reference and things. So, is the review now set and they are to come along, or are they to scope out the review further?

Ms Stevens: Terms of reference have been developed. They were discussed at the first meeting of the steering group, and they were amended and were felt to be appropriate. When our trade union colleagues join us at the next steering group meeting, I have no difficulty with taking their views. If things need to change, or if, for whatever reason, there has been an oversight —

Mr McKinney: So, you will invite them to change the terms of reference if need be?

Ms Stevens: We can invite them to comment —

Mr McKinney: That will be —

Ms Stevens: Absolutely. There is no difficulty with that. We want them at the table. This is something that I want to very strongly convey to the Committee: we value very much the impact of staff- and employee-side representatives. They have played a really valuable role already. For example, in the nursing and midwifery review, we had unions at the table. They played a tremendous role in that. We engage with the staff side on every detailed workforce review. The British Medical Association (BMA) is involved in the medical reviews. We are inviting the relevant domiciliary care union representatives to be involved in that one. We see them as crucial to taking that work forward.

Mr McKinney: Given what you have just said, do you regret not doing this work earlier?

Ms Stevens: The domiciliary workforce review?

Mr McKinney: Yes; the workforce review.

Ms Stevens: We really were reliant on the service models being developed. That work needed to be done by the board. That work is now just completing, so we could not really have started the work any sooner.

Mr McKinney: What does the model look like?

Ms Stevens: I am not party to the detail of that yet because I am waiting for that to come through from the board, but it will certainly envisage a mixed economy where domiciliary care is provided by not only the statutory sector but the independent sector. We expect the model to encompass both sectors, and we are going to plan for that because we know that we rely very heavily on contracting with the independent sector. Independent sector representatives are at the table as we discuss *[Inaudible.]*

The Chairperson (Ms Maeve McLaughlin): Can I come in on that, if you do not mind? Going back to the implementation plan, you talked about the joint forum with trade unions that was set up back in 2013. What happened to that forum?

Ms Stevens: A joint forum?

The Chairperson (Ms Maeve McLaughlin): Yes. It is in the strategic implementation plan.

Ms Stevens: For TYC?

The Chairperson (Ms Maeve McLaughlin): Yes.

Mr M Lee: I do not know the details of that. There is ongoing engagement between the trade unions and the Department —

Ms Stevens: Yes, and I can describe that. There is a joint negotiating forum, which —

The Chairperson (Ms Maeve McLaughlin): A partnership forum was established.

Ms Stevens: Sorry. There was a partnership forum that was in existence a while back. It fell into abeyance because both sides recognised that there was a duplication of the conversation that was happening in that forum and the joint negotiating forum. We have spent some time with our trade union colleagues looking at the structure of the joint negotiating forum and putting in place a new structure, which we are going to implement from September. That provides us with a really good opportunity to build in that partnership element and to keep trade union colleagues really closely involved in the policy development process.

The Chairperson (Ms Maeve McLaughlin): OK, but it was said to us that it was unilaterally abolished as opposed to falling into abeyance.

Ms Stevens: It had not met for some considerable time.

The Chairperson (Ms Maeve McLaughlin): But the forum was then abolished.

Ms Stevens: It was not, technically, abolished, but it was not reintroduced. That is probably a better way to say it.

The Chairperson (Ms Maeve McLaughlin): Who would have taken that decision?

Ms Stevens: It was the Department's decision because the Department chaired it. It was felt that there was another forum for that engagement to happen. I am very keen, as one of the joint chairs of the joint negotiating forum, to make that work and for that engagement to happen through that.

Mr McKinney: What about timescales, then? You talked about the end of 2015 in terms of the scoping exercise.

Ms Stevens: In terms of the whole workforce review? In its work to develop the new service delivery model, the board has gathered together a tremendous amount of information, which, in effect, speeds us along. The group is confident that it can pull that together and come up with workforce recommendations by the end of this calendar year.

Mr McKinney: What happens then?

Ms Stevens: Then we will look at those recommendations. At this stage, it is too early for me to say, but we want to look at the skills mix that is necessary to take forward the provision of domiciliary care, the levels that people need to be at and the composition of the workforce currently. Do we need to recruit, or do we need to put in place some sort of career-progression pathway to make it attractive to younger people? Our intelligence is that it is very much an older-people delivery model in that there are older people in the workforce delivering the care. All those elements need to be taken forward, and we need to look, with our colleagues in the Department for Employment and Learning, at the training that is offered, because it will more likely be done in a further education setting. We have all that to work through.

Mr McKinney: Why do you say further education setting? Oh, sorry; I thought you meant FE settings, as in —

Ms Stevens: Well, vocational training, yes, if they need further training it could be in the area of NVQs. These are areas that we need to look at.

Mr McKinney: That is domiciliary care. You have mentioned other forms of workforce reviews. Have you other plans for care workforce reviews?

Ms Stevens: Yes, in terms of social care more broadly. At the moment, the focus is on domiciliary care, and we are conscious that we need to look at paramedics. We have highlighted the whole dental profession and, more broadly, social care would probably come after that in a rolling programme. That is a matter for discussion with the regional workforce planning group. In fact, if the work on domiciliary care throws up something that we think needs to be looked at sooner, we can do that.

Mr McKinney: Would you accept that the approach to date has been too silo-based?

Ms Stevens: No, I would not accept that. I am trying to be really objective about that because in everything that we do, we try to be as inclusive as possible. We bring together the key stakeholders who we know have a vested interest in the outcome, and we want their views. I do not think that it has been done on a silo basis. Traditionally, the approach has been uni-professional. To date, that has been because we rely on those workforce reviews to determine whether we need to train more doctors and nurses. In recent times, our understanding has shifted as part of the whole new way of thinking under TYC. We need to look at things on a much broader basis, with the patient and the client at the centre. We need to look at the older person and the cadre of professionals who need to be around that person in order to deliver care. That means that it is slightly messy from a workforce planning point of view. It means that we also have to do uni-professional reviews, but alongside, as opposed to instead of, the others. Does that answer your question?

Mr McKinney: Would you accept, at least, that a lot of your thinking has been around those in the employ of the trusts or within your employ, as opposed to looking at GPs and, potentially, community pharmacy and the wider workforce employed in domiciliary care, for example?

Ms Stevens: I do not agree that it has very much been focused on the trusts, but I would agree that it has been very much focused to date on single professions, wherever they happen to be. That could be GPs, pharmacy or wherever, but to date it has been on a uni-professional basis. That is now changing.

Mr McKinney: It appears that when something erupts, corpuscle-like, in the system, not just in terms of workforce planning, the resource goes to deal with that pressure point and the wider strategic thinking may not have been employed in the way that you are talking about now.

Dean, you mentioned GPs. There are 25,500 people waiting for first referral to a physiotherapist and some 12,500 for occupational therapy. What consideration is being given to allowing self-referral? It goes back to what I am saying about dealing with the pressure point. Your immediate reaction is to train more GPs, whereas you could take the strain off the GPs and allow self-referral to allied health professionals and the range of services that they provide.

Ms Stevens: I will let Dean answer that, but, before I do, I will point out that it is not our first reaction to say, "Train more GPs". It is not.

Mr Sullivan: And we have done that, as I said we would, when I was here two times ago. That pilot is up and running now in the South Eastern area. There is direct referral to physio in the South Eastern area.

Mr McKinney: Dean, there are still 25,500 people waiting for first referral. We cannot really get past those figures.

Mr Sullivan: I fully accept that, and those figures are very difficult. However, it comes back to a couple of things that are not directly related to workforce planning in relation to allied health professionals, because there is not particular difficulty in securing additional staff resource for the majority of the allied health professionals. The greater difficulty is simply funding additional capacity, whether that is short-term or longer-term capacity. An exercise that has taken quite a time to complete will be complete, I expect, in the coming few weeks in relation to better understanding exactly the

flows of patients into the system for various allied health professional services and the capacity of the system to respond to that. That will flag up areas where there are pinch points and for which, again, in the wider resource context, it will not be straightforward for us to address. We simply cannot put our hands on additional funds to address that, but at least we will be clear about where there are opportunities for trusts and staff in trusts to be more productive, and there are issues that are just barn-door demand issues. We will need to look at that.

You could ask me about elective care waiting times in other areas, for consultants and so on, which we have rehearsed before. We face the same challenges there. Our approach in AHPs and, more generally, referrals for consultant services is what I was talking about earlier, which is that, as things sit at the minute, we have no prospect of material recurrent additional resource going into the system. Therefore, we have to look, in ways that are as imaginative as possible, at existing staff, be it GPs and nurses in primary care or doctors, nurses, allied health professionals and other practitioners in secondary care, working differently to try to not let this get too far away from us. I would not try to understate the problem at all; there are huge challenges out there in the system.

Mr McKinney: It goes back maybe to the question that the Chair asked at the start about who is actually in charge of some of this. Clearly, as you have touched on, there will be resource implications out of the workforce review, so trusts employ directly and the private sector provides some itself etc. Overall, who is in charge of making sure that we have the adequately trained, properly directed staff looking at the service model as it emerges?

Ms Stevens: I see it as a cyclical thing. The board and the PHA work to determine what the service model for delivery is. They instruct the trusts and contract with the trusts to deliver that. The trusts' obligation is to make sure that they have a workforce that is suitably trained to do that. If there is a problem in the supply chain, they flag that to the Department, and we have to see whether that is a training issue or an issue that is more about how you are recruiting your staff and how you are retaining them. Is there something at that point that needs to be done as opposed to starting to feed a supply chain through training? That is an expensive way, and it is a lengthy way of getting people into the workforce. In some cases, the need is such that we have to do that, but, in some cases, actually what we need to do is to just keep the people that we have.

Mr McKinney: Finally, how do we make sure that the model that emerges is a mixed economy and that the service level is of the same quality not a floor? There will also be issues around pay and conditions that will differ. Does that have an impact on delivery of care beyond the floor?

Mr Sullivan: The service delivery model is ours to determine, Fearghal. It will be done in partnership with providers and in discussion with patients and clients, but it is for us to determine. There is legislation about the requirements of the specific behaviours, policies and so on of employing organisations in the private sector. We would not get involved in that directly, other than in tendering arrangements, obviously, and being assured that any organisation is consistent with those.

Mr McKinney: At the moment there is huge stress on the private-sector end of this. You will be aware of it from the headlines in the papers, we have heard it in evidence and I am sure that all our offices are aware of it too. The folk who tendered the contracts are, even at the outset, undermining potential safety and care.

Mr Sullivan: What I am aware of is that we have tendered, and will continue to tender, for services to put a sensible and deliverable service specification out for any appropriate provider to respond to. Before we accept a tender response, or if it is a sub-contractor to a trust, before a trust would accept a tender response, they would undertake due diligence to satisfy themselves that what is being put forward is not at such a price that it is undeliverable. If we go back to the elective care side of things, we do not tender for that at a floor price for whatever organisation comes through. Typically, our expectation is that the price that is brought forward is consistent with the tariff across the water. The tariff across the water is one that has gone through a huge amount of work to ensure that it provides a reasonable return for the organisation delivering the service. I can see how what you are describing is a risk, but I am satisfied that the tendering arrangements that are in place should avoid what you describe. The risk is there, but I am satisfied that there are mitigating factors in place to address it.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thank you for the presentation. Did the Department consider a voluntary exit scheme for Health and Social Care (HSC) when undertaking workforce planning?

Ms Stevens: Yes, the Minister has approved a voluntary exit scheme for HSC, and a bid for funding has been submitted to the public sector transformation fund. Being able to proceed with that, however, will be entirely dependent on securing funding. The trusts have carried out modelling of who may be able to avail themselves of the scheme in parallel with, and in order to implement, their savings plans. They have looked at areas where savings are required, and they will offer the opportunity for voluntary exit in those areas, if funding is secured. I cannot stress enough that it is if the funding is secured. Workforce planning, in the round, has to take account of that, but that will proceed in relation to implementing their savings plans.

Ms McCorley: Are you saying that you do not have any estimate, at the minute, of how many workers might take up the scheme?

Ms Stevens: Our initial estimates are in the region of 400 people across the whole health and social care sector. The Minister has made it very clear that he does not expect front-line staff to be released as part of that. The fact that it will be in areas other than front-line staff certainly ties in with the savings plans that have been put forward.

Ms McCorley: Is there still a policy of no compulsory redundancies in the HSC?

Ms Stevens: Yes, the Minister has made it very clear that we are not looking at compulsory redundancy.

Ms McCorley: You are saying that it is not on the cards? That is not going to happen?

Ms Stevens: Not to the best of my knowledge. That is what the Minister has said, and that is what we are working towards.

Ms McCorley: You mentioned a figure of 3%, which was a reduction in Transforming Your Care. Can HSC explain how that was arrived at in the first place? It is a figure that we have probed several times, but we have never had a satisfactory response.

Mr Sullivan: I doubt that I can give you one today, Rosaleen, I am afraid. I would describe a very complex set of issues that would change the number of staff in individual parts of the workforce that are required to deliver individual services. I will stick with the example of outpatients that we described today. I talked earlier about outpatient reform for, say, something like dermatology. If there were, which there are, opportunities for fewer patients to be referred into secondary care for consultant outpatient appointments, all other things being equal, that means that we potentially need fewer staff, doctors, nurses and others in secondary care to respond to that. That assumes a system that is static and perfectly in balance at the minute. We are not static and perfectly in balance, as Fearghal described earlier in relation to AHPs. We have a position now where thousands of patients are waiting more than nine weeks for a first outpatient appointment. The reality may be that we need to keep all the staff in secondary care that we have there now in dermatology, and, in primary care, we will simply bring the system back into balance rather than create headroom so that we can reduce the number of staff in secondary care.

Straightforwardly, I do not know where the figure of 3% came from. I think that perhaps, consistent with what Heather said, it was intended to signal a direction of travel that our default position going forward has to be that, where it is appropriate, safe and cost-effective to deliver care near to someone's home, that is exactly what we do. Where it is appropriate, safe and cost-effective to deliver care in an ambulatory setting rather than admitting someone to hospital, that is what we do. To give a flavour of what that might look like, the figure of 3% was arrived at. I do not know the extent to which that took account of demographic change, as we have talked about around this table before. There has been a 2% increase year-on-year. In the time between when TYC was published and now, there has been an 8% demographic growth alone. So, was it 3% assuming no demographic changes? That would swamp any 3% that was talked about at the time. Just to stand still, we would have needed to have increased the workforce by 8%. That is before we begin to think of all the other complicating factors.

Caroline and I work very closely with the Royal College of Nursing (RCN) and others on normative nursing. That, as an example, is not responding per se to demographic pressures, whether we are looking at phase 1 in terms of nursing staff on medical and surgical wards. That is simply us working

in partnership with professional colleagues and identifying reasonable staffing levels for medical and surgical wards. In most trust cases, that required an increase in permanent and temporary staff working on those wards. As we talked about before, there are plans in place, which are being implemented now, to work towards that position. That would not have been foreseen or foreseeable at the time when TYC was written, but it will result in an increase, just on its own, of hundreds of nursing staff working in a hospital setting. That is the challenge. There are so many inflows and outflows from all this. If you did arrive at a -3% figure, it would be as much by luck as by judgement, and I do not think that, if anything, that would be the direction of travel. It is more in the context of TYC signalling a direction of travel. You should be, and I know you are, looking for demonstrable evidence from the Department, the board and trusts that we are not just routinely investing in secondary care services and more staff in there but are actually looking very hard all the time at opportunities to provide care closer to patients' homes and investing in staff to support the delivery of that model.

Ms McCorley: It comes back to this question: where did the figure of 3% come from? I understand all the different aspects that you are talking about and that it is hard to predict, but somebody came up with 3%, and we have never been able to get a satisfactory answer. It makes you wonder what else in there was plucked out of the air. You cannot have much confidence.

Mr Sullivan: Hopefully nothing else, Rosaleen.

Ms McCorley: How do we know?

Mr Sullivan: I guess that you can take assurances from the discussion that we have had today. Hopefully, there is nothing else, but it would be hard to explain the figure of 3% and come up with a strong rationale for it.

Ms Stevens: Absolutely. It was certainly never endorsed by the Department and did not find its way into the final document.

Mr M Lee: It should be seen in context. A document was published at the end of 2012 or in early 2013 that stated that we had Transforming Your Care, which sets out a strategic approach to changing our care. What does that mean for our system? It sought to set out some of the implications and working assumptions. If it is helpful, we can enquire about how much of the history is still on record on how 3% was arrived at to see whether someone kept background calculations. As I said, however, the key thing is that the document sought to start a public discussion on what TYC meant.

We might see a shift from the hospital sector to the independent sector as a consequence of TYC. As part of the document asking what the public thinks about TYC, it was trying to say what that might mean for the way that service delivery happens. We can look to see whether any material was kept anywhere as to how the 3% was arrived at, but, as I see it, it was intended to be illustrative. From what I can remember, it was not reflected in the specific proposals in the strategic implementation plan. It was about trying to inform a public understanding and debate on what the shift to the TYC model of care meant.

The Chairperson (Ms Maeve McLaughlin): May I just ask on that —

Ms McCorley: I am no wiser.

The Chairperson (Ms Maeve McLaughlin): — if you do not mind, Rosie? Why put the percentage in? Why did it appear?

Mr M Lee: I do not think that any of us here put it in the document or wrote the document, so it is very hard for us to answer that. My reading of the document as a whole is that it is about trying to have a public debate on what the move to the TYC model of care meant.

The Chairperson (Ms Maeve McLaughlin): People were also being asked to sign up to a vision and policy direction that clearly said that that required a 3% reduction in staff.

Mr M Lee: I do not think that it said that it required a 3% reduction. I think that it said —

The Chairperson (Ms Maeve McLaughlin): It was in the document in black and white. I do not know how much clearer it could be. What happened, Heather? You indicated that it never got as far as the strategic implementation plan. What changed, then?

Ms Stevens: It was a working assumption in a board response to the original TYC document. It did not appear in the next iteration.

The Chairperson (Ms Maeve McLaughlin): It was not in the strategic implementation plan.

Ms Stevens: It was not taken forward.

The Chairperson (Ms Maeve McLaughlin): Something obviously changed with that working assumption.

Ms Stevens: Yes, and that will presumably have taken place in discussions in the board.

Mr Sullivan: I will interpret it. I cannot give a straightforward rationale for the 3%, but I could spend all afternoon, if you let me, giving you examples of things that we are doing that are entirely consistent with that. Palliative care is one example. There are 15,000 patients in their last year of life, plus or minus a bit at any point in time. We know about 5,000 of those, so 10,000 patients who are in their last year of life are not formally known to the Health and Social Care system, with care plans or advanced care plans setting out their health and social care needs, and their emotional needs and expectations. A lot of those patients are dying in hospital, where they do not want to die and where their families do not want them to die.

The arrangements that we have in place, through a regional steering group that I chair with Mary Hinds, the director of nursing in the PHA, are looking at processes whereby we will be able to identify as many of those patients as possible and be much closer to the figure of 15,000. We will have a care plan — an advanced care plan, if appropriate — for each patient and a nominated key worker. In many cases, but not all, it is likely that that nominated key worker will be the district nurse. That will put an additional burden on the time of the scarce resource that is district nursing, but that feeds straight through to normative nursing, and we have had discussions as part of the normative nursing process. That factor is being built into the modelling of the district nursing resource that is required in Northern Ireland. Again, that is an example whereby, in a do-nothing scenario, we have extra nursing, medical and porter staff in hospitals.

By comparison, if those patients are not dying in hospital but in their own home, a nursing home or another place of choice, that investment is being made in the community. What does that mean in practice for palliative care? Whilst the impact on bed days is material, it is a bed here and a bed there across Northern Ireland. It is nearly impossible to get that out of the system. What it means is that, compared with a do-nothing scenario, there will be investment in primary care to support GPs, district nurses and others that would otherwise have been made in secondary care to buy additional beds. When it comes to putting a definitive hard number on that, I know the number of beds and the impact on district nurses, but we still have to work through some more detail to reassure the Committee that all our focus is in this space.

The default position is not that we do what we have always done. The default position is the exact opposite. Fifteen thousand patients, some of whom are probably from the families or extended families of us all, are unnecessarily and against their wishes dying in hospital, either because we have not identified them or not put the wrap-around services in place to allow them to die at home. Just as a very hard example — I may be reassuring you, Fearghal, about the system joining up — that strand of Transforming Your Care directly leading into normative nursing is more joined up than you might think. Maybe we need to have more conversations like this to reassure you.

The Chairperson (Ms Maeve McLaughlin): I am sorry, Dean. I get it about the links, but, if we are saying that the 3% is a working assumption, it is no longer accurate. What is the guesstimate? To shift service delivery left and £83 million from acute to community or primary care, what, roughly, are the staffing requirements?

Mr Sullivan: That leads us into discussions about what we mean by a shift left. The example I gave from palliative care is a shift left every day of the week. A patient who, in scenario A, would have died in hospital, in a reformed scenario, dies at home or in another appropriate place. If, in scenario A, I

am taken to an emergency department and then admitted to hospital and an ambulatory or same-day/next-day service is put in place, still in hospital but avoiding my being admitted to hospital, that is still a shift left. It would be possible, and, indeed, I believe that we have put a ballpark figure of £70 million or £80 million on this. To me, it is about being assured that all possible opportunities are being taken by the Department, by commissioners and by trusts to move care left, closer to people's homes, putting them back in charge of their own care as far as possible and supporting them to live independently. As I say, we could fill the afternoon with such examples. If it is seen as helpful to try to scale that to give you an idea where we are and where we might be going —

The Chairperson (Ms Maeve McLaughlin): I find it irregular that a figure was used. We are listening to what you say, and we heard that it was a working assumption and that we do not now need a 3% decrease in staff, but we do not know what we need. There is no indication of our staffing requirements to implement the policy direction.

Ms Caroline Lee (Department of Health, Social Services and Public Safety): May I add a little on the education budget? We can show that community practice placements have increased dramatically. In 2011-12, we had 39 nurses in training for community placements, district nursing, health visiting, community mental health, community children's and community learning disability. In the following year, that increased to 54, then to 84 and 94, and the plan is for 97 this year.

The Chairperson (Ms Maeve McLaughlin): I am sorry, Caroline. I accept that, and I accept that work is going on in specific parts of the system, but I am talking about the overall figure. Heather, maybe you need to answer this to provide us with the means to shift left. In general, what do we need in terms of workforce?

Ms Stevens: I struggle to see how we could do that. It presupposes that we can immediately say that we will look at all the service models, say what needs to happen and aim for a certain figure.

The Chairperson (Ms Maeve McLaughlin): I struggle to comprehend why we did it in the first place. Why was it there in black and white that we needed to deliver a figure of −3% of the workforce? Why would we do that to start with?

Ms Stevens: We cannot give you an answer, because we also struggle with that figure as a working assumption. I do not think that we can ever put a figure on it, because this is an iterative process that we need to work through, and it will involve people changing roles but probably still being shown in the statistics as being employed by a trust and working in a hospital while the actual nature of their role has changed. How can we measure that in a meaningful way?

The Chairperson (Ms Maeve McLaughlin): There is no estimate, no figure and no target.

Ms Stevens: No; there is no figure that we are working towards.

The Chairperson (Ms Maeve McLaughlin): It is not, however, a decrease in workforce.

Ms Stevens: What we are seeing is an increase.

The Chairperson (Ms Maeve McLaughlin): Right, but we do not know how much of an increase.

Ms Stevens: No. There is no target for that.

The Chairperson (Ms Maeve McLaughlin): Sorry, Rosie, I was just trying to tease that out.

Ms McCorley: This question is probably not necessary. I was going to ask you whether there was an estimate of the overall size of the workforce required and whether there has been any advance budgeting to see whether it is affordable. However, you are saying that you do not have an estimate.

Ms Stevens: No. We cannot do it in that way. We have to look at it as the process develops in different areas, and the service models become clearer. We look at it on that basis.

Mrs Cameron: We have already talked about trade unions. However, a wide range of professional bodies — the BMA, the Royal College of Nursing, the Royal College of Midwives, the Allied Health Professions Federation and the Northern Ireland Association of Social Workers — told us that they would like to be on the regional workforce planning group. As a Department, are you considering expanding to include those organisations?

Ms Stevens: We had a conversation about the membership of that group when we completed the work on the framework. We felt that we needed to make sure that we had an inclusive process, because we absolutely recognise the value of those stakeholders in the workforce planning process. However, we need a system and a structure that is manageable and in which we can, in practical terms, facilitate meetings that are meaningful. That in itself provides an inherent tension.

At the minute, the proposal is that we have a fairly tightly subscribed regional workforce planning group but a wider stakeholder engagement group that involves all those organisations that you mentioned and many more, such as the Northern Ireland Medical and Dental Training Agency (NIMDTA), the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) and all the organisations that have a training role. The list is really quite extensive, and we could not have everyone round the table. In the joint negotiating forum (JNF) alone, for example, at least 12 trade unions are represented. We have a massive number of stakeholders to manage, and yet we want them to be involved in the process. The structure that we envisage involves key stakeholders who have a direct interest in particular workforce reviews and are very closely involved in the steering of those workforce reviews. Nursing is an example, and I have already spoken about domiciliary care. They are absolutely at the table, and it is the right table for them to be at to be able to influence the direction of the work and the recommendations. In wider stakeholder engagement, we can keep them informed when we are looking at areas that are perhaps less relevant. That is the model that we are working through. If that model does not work, and people feel that they do not have the level of engagement that they want, I am quite happy to review it and to look at how best we can engage people, but my priority is to have a model that is manageable, fit for purpose and does the job.

Mrs Cameron: I take your point, but the Royal College of Midwives, the Royal College of Nursing and the BMA are at such a level that they should have been in from the very beginning of the process.

Ms Stevens: They were, absolutely. They helped to scope and shape the nursing and midwifery review, and they agreed the recommendations. There is nothing in there that they did not have the ability to influence. The BMA has the opportunity to be involved through the specialty reviews. It has been involved in workshops in the general medical review. It was at the table for that.

I described the JNF structure, which is the non-medical staff side representatives. We also regularly meet the BMA and the British Dental Association in other forums, and we have the opportunity to discuss those things there, so there is engagement.

Mrs Cameron: Why are there departmental leads only for doctors and nurses in the Chief Medical Officer and the Chief Nursing Officer? Why are there not leads for pharmacy, dentistry or allied health professionals?

Ms Stevens: The remit of the Chief Nursing Officer includes allied health professionals. The remit of the Chief Medical Officer includes pharmacy, and there is the Chief Dental Officer. They are implicitly involved through that membership. However, as we take forward proposals for a dental workforce review, I have been working closely with the Chief Dental Officer in shaping up what that might look like and to make sure that it includes the range of dental care professionals. We are looking not just at qualified dentists but at dental hygienists and the full range. They are closely involved in that work.

The Chairperson (Ms Maeve McLaughlin): I am anxious to pick up on something that Pam said. Seven of the eight organisations that we spoke to did not feel that they were actively participating in the process, despite what you are saying about engagement. Except for one organisation, they did not feel that they were active participants in the process.

Ms Stevens: I suppose that that is because they are equating active participation with membership of the regional workforce planning group and not looking beyond that. The membership of the steering group oversees the particular workforce reviews, which is where their voice can be most powerfully

heard. They are at those tables. I am disappointed that they have not reflected that back to you, because that really is the key place for them to exercise influence, and they are at those tables.

The Chairperson (Ms Maeve McLaughlin): I have to say that that was a pattern with all those sectors and organisations, bar one.

Ms Stevens: I am disappointed that that is their perception, because that is certainly not the intention. We need them at the table, and our discussions in taking forward those areas of work are the poorer if they are not there. We recognise that.

Mr G Robinson: Thanks to the team for your presentation. We heard from the Scottish Government that they also experience recruitment and retention issues in healthcare. They have initiatives such as rural fellowships, salaried GPs in rural areas and the recruitment of GPs from the EU. Has our Health Department considered any of those initiatives?

Ms Stevens: We are starting to look at that. I will let Mark come in later, specifically on GPs. We have been looking more generally at hard-to-fill medical posts to see what other countries are doing to attract and keep people. This is a problem the world over, so it is not unique to Northern Ireland, but other countries have come up with other ways that are connected not to salary levels but to other things. By and large, those crystallise around additional leave. What highly qualified and skilled people in stressful jobs probably want most of all is time. They want extra time between shifts, extra leave and extra long-service leave if, for example, they have worked for a long time. We have gathered that from the information.

A European study that looked at this issue is about to publish later this month or early next month. We await with interest what it recommends as successful mechanisms to be able to retain and recruit staff. We are very keen to look at it.

There is a cost, so we have to be mindful of that. Even if we are saying that this is not about increasing salary levels, there is a cost to everything that we would do, including giving people time off; that time has to be filled in some way. It will not be easy, but it must be better than the current situation in which we have vacancies and locum spend. It is about the better use of that money.

Mark, do you want to comment on doctors?

Mr M Lee: Sure. We are happy to take good ideas from wherever we find them. You mentioned salaried GPs. There are 80 salaried GPs working in Northern Ireland at the minute. A number of those work for trusts, perhaps as out-of-hours GPs. I am having discussions with some of my colleagues at the board about whether we could make more use of salaried GPs for some services. We are looking at things like the GP development scheme, through which people return to or start to practise in Northern Ireland when they have come here from another country to see whether we can make it more attractive and easier to bring people back into GP practice in Northern Ireland.

The GP package that the previous Minister announced on 1 April includes a pot of money to look at recruitment and retention issues and to see what more we can do. We are certainly seeking to explore ways to ensure that the GP workforce in Northern Ireland increases, or at least does not decrease, alongside looking at increased training places and the skills mix in primary care, including whom we can use alongside GPs to make the most of them.

Mr G Robinson: Has the Department looked at debt relief for student fees as an incentive for hard-to-fill medical posts?

Ms Stevens: That is like a bonding scheme. That approach is certainly being looked at in other areas. We are open to looking at it as a way of helping to prevent people who have been trained here from leaving. Obviously, we cannot ever prevent people leaving — there is free movement; people have to be able to leave — but we can incentivise them by saying that we will start to pay off student debt for every year that they stay. We need to explore that proposal alongside a range of other things and come to a view.

Mr G Robinson: From what you are telling me, it seems to be a work in progress.

Ms Stevens: Yes, it is a work in progress. It is another strand of the workforce planning agenda. I am keen to say that it is not all about increasing training places; we have to look at keeping the people we have.

Mr G Robinson: With modelling and the ratio of training places required to fit the number of staff required, is the Department taking into account things such as maternity leave and the move to more part-time working as a result of work-life balance and caring responsibilities, or is it still working the 1:1 ratio?

Ms Stevens: Absolutely; all that is factored in. We know —

Mr G Robinson: That is all factored in as well.

Ms Stevens: Yes. More professions are more affected by a higher proportion of females and a higher proportion of people taking maternity and paternity leave.

Mr G Robinson: Given the role of primary care under TYC, how is the Department, when planning GP numbers, taking into account the growing number of women GPs and their need for part-time working and maternity leave?

Mr M Lee: Heather will pick up on the GP numbers. One positive development is the work that the BMA has led on GP federations, which will provide more flexible employment. You might have more part-time posts across a number of practices or delivering a particular specialism. We need to continue to work on that so that women who want to work part-time can be facilitated rather than being lost to the workforce.

Ms Stevens: We factor that into the numbers. We find that it can take longer for women to come through their GP training because they want to take time off. A high proportion of women want to train as GPs, so the specialty is very female-dominated, but it takes longer for them to come through. It is a delay on the Department's return on investment for training them, but it is just a delay, and they will come through. The Department has invested in their training, so it is important that there are opportunities to keep them on those terms, whether that be part-time, flexible working or whatever. We need to be responsive to that and to recognise that that is the demography and profile of the profession, which is absolutely crucial to TYC. We need to be mindful of that. We factor that into the length of time that we expect GPs to take to complete their training, and it is usually longer than the minimum period.

Mr G Robinson: Chair, with your indulgence, this is my last question. Is the Department looking holistically at moving to seven-day services across the spectrum? That was mooted fairly recently. A sustainability and seven-day services task force has reported to the Scottish Parliament. Does our Department have anything similar?

Ms Stevens: Both pay review bodies — the Doctors' and Dentists' Review Body (DDRB) and the NHS Pay Review Body (NHSPRB) — were asked to make observations on the barriers and enablers to seven-day working in Northern Ireland. The NHSPRB report has just been published, and we expect the DDRB report shortly. Those will set out the context in Northern Ireland, what is holding us back and what they think would help us to move to that process.

As I am sure Dean will vouch for, we already deliver a huge number of services on a seven-day basis, and, increasingly, we are seeing the allied health professions moving to seven-day services. It is really a case of the consultant workforce catching up with what other parts of the workforce are largely doing. Nurses do it, junior doctors do it and social care does it — everybody is doing it.

The important thing with seven-day services is that we are not trying to move to a situation in which someone is taken in at 2.00 am for a very serious operation and discharged in the middle of the night. It has to be about high quality and providing the right service at the right time.

Mr G Robinson: Will there be consultation with local GPs on that aspect?

Ms Stevens: Absolutely. They will have had an opportunity to feed into those reports as well. They will have been approached by, for example, the Doctors' and Dentists' Review Body to get their views on the barriers and enablers, and they will have had that opportunity. As the Department reflects on

their observations and decides what needs to be done, we will, of course, engage with them again through our channels.

Mr G Robinson: That is grand. Thank you very much.

The Chairperson (Ms Maeve McLaughlin): In a similar vein, is there a ratio for GP training?

Ms Stevens: A ratio, as in —

The Chairperson (Ms Maeve McLaughlin): How many training places there are. I know that Scotland has one.

Ms Stevens: We fund 65 training places.

The Chairperson (Ms Maeve McLaughlin): No. Scotland has a ratio of training places to provide a GP, and it is something like 1·6 for one GP. Do you have a ratio?

Mr M Lee: Is it the number of GPs we get out of the system for the number whom we train?

The Chairperson (Ms Maeve McLaughlin): Yes.

Ms Stevens: We could calculate that. I do not have that figure to hand, but we could work it out.

Mr M Lee: It varies quite a lot by year, Chair. We would need to find some way to show that.

Ms Stevens: They also take longer to come through. Our sense is that GPs take longer to come through because they are more likely to take breaks in their training.

The Chairperson (Ms Maeve McLaughlin): I thank you for your presentation. We will reflect on what we heard as we take the review forward. Thank you for your time.

Ms Stevens: You are very welcome.