Committee for Health

OFFICIAL REPORT
(Hansard)

Briefing by Chief Medical Officer and Chief Nursing Officer

16 June 2016
NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Paula Bradley (Chairperson)
Mr Gary Middleton (Deputy Chairperson)
Ms Paula Bradshaw
Mr Robbie Butler
Mr Gerry Carroll
Mrs Jo-Anne Dobson
Mr Mark Durkan
Ms Catherine Seeley

Witnesses:
Ms Charlotte McArdle Department of Health
Dr Michael McBride Department of Health

The Chairperson (Ms P Bradley): I offer a warm welcome to Michael McBride and Charlotte McArdle. I remind members that you will find the Chief Medical Officer's annual report — I have the glossy one with me — in the papers at page 12, if anybody wants to look at it during questions. Hopefully, you all had a good look at it before the Committee meeting anyway. Michael and Charlotte, it is over to you.

Dr Michael McBride (Department of Health): Chair and members, thank you for the invitation to come along at such an early juncture to the new Health Committee. It is a pleasure to be here. I sent a paper outlining the main areas of responsibility I have as Chief Medical Officer. I am not proposing to go through it in huge detail, but I will highlight a few issues, if that is helpful to the Committee.

The Chairperson (Ms P Bradley): Indeed, I remind members that the paper Michael sent through is in the tabled papers from pages 3 to 7.

Dr McBride: Obviously, my role as Chief Medical Officer has many facets. I have roles outwith the Department of Health in Northern Ireland, working at a national level with my three counterparts across the United Kingdom. I also have responsibilities here in Northern Ireland providing professional medical and environmental health advice to Ministers — the Health Minister and, indeed, other Ministers — and Departments. That covers public health policy, including health promotion, disease prevention, emergency planning, health protection and environmental health. I also have policy responsibility for safety and quality standards. That includes the standards we set as a Department for Health and Social Care and the policy by which we seek to improve the care that patients and clients receive.
I have outlined the structure, which falls into two main areas, as you can see. On safety and quality policy, I am very ably assisted by my Deputy Chief Medical Officer, Dr Paddy Woods. Dr Woods is responsible for the quality, regulation and improvement unit and the safety strategy unit, which are subsets within that area. The quality regulation and improvement unit has responsibility for two main planks of work: death certification policy and the legislative branch. It sounds a very dry title, but it is a hugely important issue in improving and enhancing the existing process for death certification. It has policy responsibility for rolling out the regional morbidity and mortality review system, which will be the first of its type in the United Kingdom, an important piece of work. The unit also has responsibility for considering proposals to appoint an independent medical examiner in Northern Ireland to independently review deaths that are not investigated by the coroner, and it has policy responsibility for the important area of personal and public involvement, which, from 2009, has been on a statutory basis.

The second area in that is the quality regulation policy and legislative branch, which, again, has responsibility for sponsorship of our Regulation and Quality Improvement Authority (RQIA). It leads on the policy of developing care standards for our regulated service, which is a very important area promoting the use of evidence-based standards, such as those developed by the National Institute for Health and Care Excellence (NICE), and has responsibility for formally endorsing NICE guidance, technology appraisals and then overseeing the process by which that is implemented by our Health and Social Care Board (HSCB) and trusts in Northern Ireland.

The safety policy unit is the policy lead for a very important area of work that I work closely with Charlotte. That is the implementation of Quality 2020, which is our 10-year strategy to protect and improve the quality of health and social care in Northern Ireland. Again, in that area, colleagues have responsibility for serious adverse incident reporting, the Health and Social Care complaints procedure and safety alerts to the Department advising of the early warning of potential issues in the health service. Also in that unit there is responsibility for the Northern Ireland medical devices alert system. If there is a problem with the manufacture of a particular piece of medical equipment, that area is responsible for producing alerts and advising the health and social care system of the problem and coordinating the response. It also has responsibility for the important area of decontamination policy to ensure that the equipment we use in providing health and social care is appropriately decontaminated and care is provided safely.

I now move into the area of public health policy, which features largely in my annual report this year. I am assisted ably in that by Dr Anne Kilgallen, Deputy Chief Medical Officer, with responsibility for Making Life Better, which is the Executive's strategy for improving the health and well-being of the population. Again, there are important strategies underpinning that on obesity prevention, alcohol and drug misuse, sexual health, skin cancer prevention and suicide prevention. I will not read the list to you; it is in front of you.

Also in my area of responsibility and working in my team is the chief environmental health officer, Mr Nigel McMahon. He has significant responsibilities for ensuring that there is advice to the Department and other Departments on environmental health issues, legislation and policy. Moving into pharmacy advice and services, the chief pharmaceutical officer is Dr Mark Timoney. Again, that is a very important area of work on medicines and pharmaceutical issues, such as policy, standards and legislation and — this is a particularly important area — medicines optimisation.

Finally and not least, there is the important area of oral and dental health. Again, I am advised and supported by the professional lead in that area, Mr Simon Reid. He is responsible for providing advice and support to the Minister in all matters relating to oral and dental health and services.

That is a brief snapshot of the breadth of the areas of responsibility; I have not necessarily gone into the depths of the detail.

At a national level, I regularly meet my counterparts. As you know from our report, we produce UK-wide guidance on important health issues. We work collectively and collegiately in that manner in the same way as our Chief Nursing Officer colleagues do and interface on a very regular basis with my counterpart in the Republic of Ireland, Dr Tony Holohan. That is a whistle-stop tour, and I hope you were able to follow at least some of it.

The Chairperson (Ms P Bradley): Thank you. Even for those of us who have been here for some time, it is always good to get refreshed on all these things. It is worth keeping hold of this; it reminds us exactly what your role in this is so that we do not stray into questioning you on something that is not in your remit.
Ms Charlotte McArdle (Department of Health): Good morning everyone. Like Michael, I have a role in providing professional leadership to the system. We have a small team at the Department headed by me, supported very ably by my Deputy Chief Nursing Officer, Caroline Lee. I then have three nursing officers and one allied health professional (AHP) officer. Our group sets the direction for midwifery and nursing specialist community public health practitioners, including health visitors, across the HSC and all the allied health professions, of which there are 12 specific individual groups.

In my role as head of profession I am responsible for professional leadership, performance and development of the workforce across the HSC. In the statutory sector, that consists of about 15,000 nurses and midwives, of whom 1,000 are midwives, and there are about 4,000 nurses in the independent sector. In total, from a registrant perspective for Northern Ireland, we have about 22,000 registered nurses and midwives with the Nursing and Midwifery Council (NMC). They are all ably supported by a workforce of just short of 5,000 healthcare support workers.

A key role for me is making sure that the Department obviously meets all its statutory responsibilities on the regulation of the profession and adhering to the standards and educational requirements laid out for the professions by the regulatory bodies, the NMC and the Health and Care Professions Council (HCPC) for allied health professionals. We also have responsibility for deciding whether nursing and midwifery professional alerts need to be issued to the system in the event of a pretty serious public safety issue. In addition, we provide professional advice and allied health professional advice across the Department and other Departments as required.

Like Michael, I have a role in working with the other Chief Nursing Officers (CNOs) in the UK and, indeed, the CNO from the Republic of Ireland. We tend to meet on a five-CNO basis. I lead work on behalf of that group across the UK on professionalism in nursing at the moment. We also feed into the wider EU agenda, particularly on regulation of the nursing workforce, movement of nurses across the EU and that kind of thing. My Deputy Chief Nursing Officer, Caroline Lee, mainly leads on the regulation of the profession. She works very closely with the Nursing and Midwifery Council. We recently implemented, in April this year, nursing revalidation. All nurses on the register now have to revalidate every three years as well as updating their renewal, and they have to provide evidence to the regulator that they are fit to be on the register. That has gone well across the four countries but particularly in Northern Ireland. Everybody has managed, from April to June, to get through revalidation smoothly. We know that in September there is a huge amount of registrants across the UK due to revalidate because that tends to be when the students register for the first time. We will have a better idea of how that is all going when we get through September.

Caroline also leads on patient experience for me and works closely with Michael's team, particularly on the Donaldson report, Quality 2020 and strengthening the voice of the patient. She also has the role for sponsorship for the Patient Client Council (PCC), which is our arm's-length body (ALB) that represents the views of patients, clients and their families in the system. The PCC provides that facilitative role and provides a link between the Department, the HSC, the user and the patient, and it feeds back to us on issues that patients and users raise or concerns they have about how well or not so well the system has worked for them.

Caroline is working with the NMC on pre-registration standards. They are all being reviewed following a review that was done in England by Lord Willis. We suspect there will be significant change to the undergraduate programme for nursing in the coming 12 months to the extent that there may well be a change to the four disciplines of nursing — learning disability, mental health, adult and children — to strengthen our ability to deliver on the challenging transformational change that is required moving forward.

Hazel Winning is the lead AHP officer. Some of you may know Hazel in that role. As I said, there are 12 groups, including art therapists, dieticians, drama therapists, music therapists, occupational therapists, orthotists, orthoptists, physiotherapists, podiatrists, radiographers, speech and language therapists and, potentially, paramedics in the future. In the other UK countries, paramedics are part of that AHP group, and we are working with the Northern Ireland Ambulance Service to explore that in Northern Ireland. Hazel leads on the professional elements and feeds into policy development for all those professional groups.

We have nursing officer Mary-Frances McManus, who leads particularly on public health-related matters, community nursing and primary care and works closely with Michael's team on Making Life Better and the nursing and midwifery contribution to it. Given that nursing and midwifery is one of the
largest professions but the one that stretches out across all four corners of the HSC, they have a significant contribution to make to improving the health of the population and early intervention, particularly with children, through health visitors and school nurses.

We have family nurse partnerships now established in all five trusts for roughly 100 teenage mums who require that support when they become pregnant. The family nurse partnership nurse will stay with that mum until the baby reaches the age of two to ensure good support, good bonding and good development for the child and the mum in their relationship building. That has proven to be very effective. It is built on 30 years of evidence from around the world, and we hope to roll it out further across the five trusts in the coming years.

Heather Finlay is my nursing officer with responsibility for workforce planning and education. This is a significant role in workforce planning and ensuring that we have sufficient numbers and midwives to meet the rising demand in our services. Heather leads on the implementation of the nursing and midwifery workforce plan that was completed last year and is now being implemented through a number of work streams. Heather is also my lead for providing advice on international nursing issues, and I am sure it will not have escaped your attention that there is a shortage of nurses not just in Northern Ireland and the UK but across the world. Heather is working in that space. She also leads on the post-registration education commissioning processes and has responsibility for managing the budget for post-registration nursing and midwifery education, which is primarily fed through the trusts’ requirements to develop and maintain the continuous professional development for their staff but with an eye on looking at the future to what we need our nurses and midwives to do, where we need them to be and what skills they need to undertake new and different roles in the future. We suspect the forthcoming report from Professor Bengoa will influence and shape that further.

Finally, Verena Wallace is our midwifery officer. Verena is the only midwife who works in the Department, and she leads on midwifery and children’s issues. She has been heavily involved in the implementation of legislative change from the regulator on midwifery practice, which changes next year. The Nursing and Midwifery Council is removing statutory supervision from midwifery, which has been a requirement for the last 100 years, on the basis of a report on poor midwifery practice that was done in England. Because we are a four-country regulatory body, any regulation applies to the four countries. Verena leads in that area. She also provides input to the maternity strategy, female genital mutilation (FGM), termination of pregnancy and perinatal mortality and morbidity. We also produced bereavement guidance and care pathways for people who have had miscarriages and stillbirths, and Verena was heavily involved in that report.

The only other thing to mention in addition is that we have sponsorship responsibility for the Northern Ireland Practice and Education Council for Nursing and Midwifery, known as NIPEC. It is a small organisation that assists my office with the translation of policy into practice and works across the whole sector, statutory and independent, to put that into best practice and evidence and to support staff on the ground to make sure they assure themselves on standards of care. It has done particular pieces of work. It is leading at the moment on supervision for midwifery, because if statutory supervision is removed in Northern Ireland we will need our own model. It has worked very hard on Delivering Care, our model for safe staffing, with the Public Health Agency (PHA) for a number of years to move that forward. It has also been the lead in implementing the revalidation. Those are just some examples of the work it is doing. NIPEC also works with Northern Ireland Medical and Dental Training Agency (NIMDTA) in a multidisciplinary context on Quality 2020, supporting staff in development and leadership opportunities for quality improvement.

The Chairperson (Ms P Bradley): Thank you, Charlotte. Before I bring members in, it might be worth asking what you see as your priorities at this stage. I know you have given us lots of detail. I imagine workforce planning for nursing is one of them. I know that, when I sat on the Committee in the last mandate, we discussed workforce planning to the nth degree. You are telling us about the situation with nurses, that there is a shortage and that that has not improved greatly. Maybe you could tell us whether your priorities are really to do with workforce planning and what you are doing.

Ms McArdle: I am happy to do that.

Where workforce planning is concerned, as I said, there is a shortage of nurses across the world, and in my experience that tends to be a cyclical problem. The last time we had this was around 2000. We then increased numbers in training, went on an international recruitment drive and looked to see what our healthcare support workers could do to support the registrant workforce at the time. That has developed over time. We are now back in that situation, and I think there are a number of factors that have caused that. First, there is the ageing profile of the different disciplines in nursing and midwifery.
There is quite a big group in the over-50 age range that is due to retire, moving from 11% last year up to 30% by 2018. Those retirements are happening. Workforce planning is not an exact science, as you will appreciate, but many of the retirements that were due to happen have been staggered because of the economic downturn and the fact that many of the nurses and midwives were the main provider in their families and needed to stay at work longer. They are working part-time and have reduced their hours to facilitate work-life balance etc. There have been, obviously, huge demands on the service and a need for more front-line nurses. The complexity of the patients who are being cared for both in hospital and in the community has increased significantly, requiring more input from skilled nurses, all of which causes a supply-and-demand issue.

We have also had some problems with attrition of our graduates. London is particularly popular with some of our graduates at the moment. When we were doing the workforce planning, we worked out that we were losing about 20% of our graduate workforce, mainly to London. Those issues are driven by the needs of the nurses to work in particular specialties. It is a similar pattern to that you see in medicine. They choose a career in a particular field, and they want to pursue that. Because Northern Ireland is small, they do not always get all the opportunities they would like, so they move on. Because the London teaching hospitals are in such a dire situation with registered nurses, they are offering them additional packages, such as resettlement and enhancement of their salary etc, which is obviously attractive. You are competing in that space.

Those are many of the drivers of the current problem that we have. The previous Minister, Minister Hamilton, increased the number of students in training by 100, and they will start this year. Obviously, we will need to work to see what we need to do to bridge that gap for future years. It will take at least three years for those students to come out, and an extra 100 is not going to be enough. We are also working with the Open University (OU) and have increased the access routes to nursing. We are supporting about 60 nurses through the OU. They tend to be support worker staff in organisations who are more committed and want to develop a career and they tend to be more committed to their organisation, so that is a good thing to do.

We know that the average age of a student nurse entering training is about 28 across the UK. It tends to be something that people do later, when they have maybe assessed what other things are available. We also know that a significant number of those who are coming in already have a primary degree. I have commissioned work on whether we can have a fast-track programme for people who already have a primary degree in a healthcare area. Potentially, that would shorten the nurse training programme. We are also looking at master’s-level training for people who come in with a primary degree. We are exploring the options.

One of the big areas of work will be trusts' ability to support the new nurses in the areas of practice they want and to offer them the specialties they want and make Northern Ireland an employer of choice. The trusts have got together and done quite a bit of work in that area on standardisation of recruitment processes and offers to third-year students. We are hopeful that all that will help with the recruitment difficulty, but it will take time. Our international recruitment campaign is a medium-term action to support the delivery of safe and effective care for patients and clients while we work through growing our own nurses. It is not in any way a long-term solution.

**The Chairperson (Ms P Bradley):** I was going to ask you about a retention strategy, but it seems you have that in place, and it is a case of saying, “Once we have our nurses trained, we want them to stay”.

**Ms McArdle:** And they want to stay. Any of the students whom I have spoken to want to live and work in Northern Ireland, but it is about career opportunities and skills development.

**The Chairperson (Ms P Bradley):** It is probably the same amongst all disciplines in health and social care, in that to retain the staff, we need to make sure we offer them the very best to keep them here in Northern Ireland.

**Dr McBride:** I have three priorities. In my annual report, I have highlighted that, year on year from 1991, we have seen a three-month increase in life expectancy for every man living in Northern Ireland and a two-month increase in life expectancy for every woman living in Northern Ireland. That is good news. We are all living longer, but we still see significant health inequalities. Sadly, that is reflected by the fact that, in areas of social deprivation, we see higher rates of cancer, heart disease and suicide. That is something we need to fundamentally address. In healthy life expectancy — the years someone can expect to stay well and healthy — the difference between a man living in a deprived...
area, as opposed to the least deprived area, is 11.8 years and for a woman it is 14.1 years. Where you live in Northern Ireland, your social circumstances and your lifetime opportunities still determine your health and life expectancy. Through the implementation of Making Life Better in this Executive mandate, through working with our colleagues in local government and through the introduction of community planning, we will really begin to make an impact on that.

The second hugely important area is the whole remodelling of Health and Social Care. I said in my report last year on Sir Liam Donaldson’s recommendations that, on recommendation 1, “slow” and “no” are not options. The problems that Charlotte highlighted are a reflection of the fact that we need to radically transform and reform how we are providing health and social care. I very much welcome the opportunity that will be presented in this mandate with Professor Rafael Bengoa’s report and, indeed, the political consensus that heralds the outset and beginnings of that work, because I believe that, as Sir Liam put it in his report, Northern Ireland has the opportunity to have a world-class health and social care service. To allow that to happen, we need to change the rhetoric and the dialogue with those who use and work in the service and work together, in a collective way, to understand what the best model of health and social care services is for the population that we serve, not just now or in 10 years but into the future.

The third area is about the health service in Northern Ireland continuing to invest in research and innovation. We have some of the finest researchers in the United Kingdom; we punch well above our weight at a UK level. This year — you might have missed this — we were one of only five centres in the United Kingdom to be successful in applying, along with colleagues in the universities, to become a UK centre for precision medicine, which will fast-track new treatments and measures to diagnose more quickly and monitor more effectively the impact that those treatments are having on a whole raft of areas. We have also invested in a Northern Ireland genomics centre, with input from the Department and the Medical Research Council, which will radically change the diagnostic pathway for people living with rare conditions and cancers that we see in very low frequency, cutting through some of the diagnostic pathways that they currently have to go through.

Those are my three areas, and I think that all of that has to be a thread running through it. We are small enough and are able enough, as Charlotte said, with the professionals working along with the professional managers working in the system, with the support of our elected representatives, to make Northern Ireland a place about which people say, “Let’s visit Northern Ireland to see how they deliver health and social care there”. So let us talk up our health and social care services and all that we do well, recognising that there are significant challenges.

The Chairperson (Ms P Bradley): I could not agree more. We are very good in this country in general at talking down, especially health and social care.

Mr Durkan: We are not that good. [Laughter.]

The Chairperson (Ms P Bradley): Yes we are; we are extremely good at it. We forget, at times, that we have some of the most talented and innovative people achieving the most wonderful results, especially in diagnostics and different things. We get bogged down and concentrate on waiting lists, which are important, but we forget to shout and say, “This country is doing amazing things. You need to come here. You need to work here. You need to be part of our health service.” So I am glad that you commented on that. I am also glad that you brought up the report, when it comes through, on remodelling health and social care. I am fortunate enough or unfortunate enough to remember working in social care — it was two separate bodies then — and I know that our model was the envy of others throughout the UK, but it certainly needs to be —

Dr McBride: It does, Chair. You are absolutely right. We do focus on that, because, in health, we are perfectionists. As professionals, we want to do the absolute best for our patients and clients all of the time. It was best summed up by Bevan, at the foundation of the Health Service, when he said that there would never be enough resources or enough capacity, but the health service must always be changing and improving. So I think our focus will continue to be that enough is not enough; there is always more. That is the dynamic, the passion and the commitment that is in the health service. Be in no doubt that there is an appetite for reform and an opportunity to have a different healthcare system, working with those who use the health service and those who work in it. It is a very significant opportunity, and we will not be forgiven, given some of the constraints that we currently have, if we do not take it. It is something that Charlotte and I have spoken about.
Ms McArdle: Amazing work is going on in Northern Ireland across all areas of practice and the professions. When you have the opportunity to see what other countries are doing and what they are leading on, you think, "Well, we have been doing that for 10 years, but we just have not told anybody." As Michael said, people want to do their best for their patients, so they will push themselves that extra mile to do that, and they do not tell people readily about what they are doing. We need to be much better at selling the good stories and the success stories.

I look across my own professional group, and there are nurses in all sorts of fantastic roles, pushing the boundaries of practice. There are nurse endoscopists who are running their own clinics, doing minor surgery or seeing patients in the emergency departments on the same basis as the doctors. They are really keen to push and expand their roles and, at the same time, hold on to all the really good nursing principles and values of care, compassion, respect and dignity for people throughout the service. That is where you get the best of both — where you can blend the new and exciting roles with the traditional values of good nursing practice.

There are huge opportunities going forward, as Michael said, in a system the size of Northern Ireland's to maximise our opportunities to do that even more. I am very keen to hear what Professor Bengoa has to say about all of that. Everybody knows now that people want to live at home as long and as independently as possible. Our job, as a system, is to support them to do that. Nursing has a huge role to play in that space, and the more complex care that is now being provided at home needs a higher level of skill. We have to facilitate that by whatever means, within the budget that we have to enable that to happen.

Last week, a group of staff from the system visited Holland to look at the Buurtzorg model of district nursing; I do not know whether you are familiar with that, but the feedback is fantastic and the patients and the nurses love it. It is a very efficient way to run the service. Obviously, it is a different model of healthcare; it is an insurance-based model, but there are principles in it that we can take and learn from. Everybody came back very enthused about how we might, for example, take that model and roll it out in Northern Ireland. We still have some work to do around fine-tuning it and whatever, but there are opportunities to do things like that, and Professor Bengoa's report will give us a vehicle to explore that even further.

I am very keen to look at the role of advanced nursing practice, particularly in primary care, to support GPs, who are so fantastically trained and have such good experience. The sickest people need to get to the GPs as quickly as we can possibly facilitate it. By allowing other patients to see the right person with the right skills, nurses and, in particular, the physiotherapy allied health professionals (AHPs) have a huge role to play in that space. We need to facilitate nurses and AHPs to grow into those models and work closely with our GP colleagues, because it is going to take all of us together to work this out.

Dr McBride: If I can steal a footballing analogy for a moment, my message about healthcare here is that we are not Brazil, we are Northern Ireland. That is certainly the message that I want to communicate about health and social care in Northern Ireland and what we do really very well. We are not very good at acknowledging and celebrating the things that we do really well.

Ms Seeley: Thank you both for your presentation today and for coming here. Some of what I will say is just some points about some things that I think are a priority. I will start by asking Charlotte a wee bit about the nursing issue. It is probably sometimes hard to match the packages that are being offered in London. There are other issues that we have no control over around being smaller and opportunities not being as open to all. If we ensure that our working conditions are better, and if we are looking after the health and well-being of our nurses, that could be enough to have our nurses staying here. It is very important that we keep them here. What are we doing to ensure that our nurses are being looked after? They are doing long shifts and long hours — many of them voluntarily, of course, not taking their breaks. I have concerns that we need to ensure that there is support there for them and that they are being looked after. That is just a wee question that you can come back to.

One of my main concerns is around mental health. There is a report in the media this morning about the mental health of our students. It says that one in five self-harm. When they transition from school to university, there are feelings of anxiety and loneliness, and that can also result in addiction issues. So it is just to get reassurance that mental health will remain a priority under the new Minister — particularly the mental health of our young people, who find it difficult to talk about it.

I noticed in the report that you talk about a self-harm register and how that is being availed of to train staff. Now that we have trained staff and that training is ongoing, we need a strategy for how we
reach out to people who maybe do not present to hospitals when they self-harm. I think that is really important. Also, young people and men are two sections of society that do not talk about it as easily and do not think that they can ask for help just as easily, so it is about tackling that stigma.

I was delighted to hear, Michael, and to read in your report that you are concerned about the inequalities in health and access to health services. I am glad that that is going to be one of your priorities. This week is also cervical awareness screening week. I note that you talk about increasing screening in the report as well, but it is just about how we are reaching out to women. I know that they will get letters from their local GP service to remind them of their appointment, and there are these awareness weeks, but it is also about the women that we are really not reaching and what we can do. It is also Men's Health Week. Again, it is this idea that men do not find it as easy to seek help or to admit that they have an issue, and you noted that their life expectancy is lower than women’s. So it is just around tackling all those issues. They appear in the report, and I am glad to see that. It is just about how we drive them forward.

I talked last week, I talked in the Education Committee yesterday, and I am going to talk again about the importance of cross-departmental work with Education. I note in your report the guidance that is offered around many of the issues, and I have to commend you on how the report is presented. It is extremely easy to digest and very easy to read. I wish every annual report that we received was delivered like this. I have to commend you and those involved in that. It is just as important that we work with Health, particularly on children’s services — there is a huge overlap there — and on mental health issues.

You talk about pregnancy health in your report, and folic acid and how important that is for women who are pregnant. One thing that I have been lobbying extensively over and that was not mentioned — but that is not to say that it is not being thought about — is around group B strep. We do not uniformly screen for group B strep and, if we did, we would know those women who would benefit from an antibiotic during pregnancy. I do not know if that is something that we are going to look into, but I will be lobbying that we do, because children can be born sleeping as a result of it or can be born with severe learning difficulties and disabilities. That would all be preventable and avoidable if we were to bring in some mechanism for awareness — I know that you can go and get the test done yourself — but, ideally, what we would be looking for eventually is uniform screening for that.

I know that there was a lot there, but thank you.

**Dr McBride:** I am not sure that I will have time to cover all that, but I will just provide assurance to you in reverse order. In relation to group B strep, as Chief Medical Officer I have been leading a group since 2011 around group B strep, basically in response to concerns that were raised by families and parents at that time. Looking around the room, I am not certain whether any members of the Health Committee were here, but the families made representations to the Health Committee at that time. Again, it is a good example of those with concerns raising concerns and those concerns being listened to and action being taken.

To provide some background, the UK Governments take expert, scientific advice from the UK National Screening Committee on the balance, because there is always a balance between screening for something and what you do when you find that there is something, and whether or not the management or treatment of that is actually beneficial to the individual patient. That sometimes seems like a complex argument, but we take advice on screening for all conditions, whether it is aortic aneurysm, cervical cancer or cytology, from the UK National Screening Committee. The committee reviewed the evidence base for screening for group B strep at my request, back in 2012, on the back of the engagement with families affected. It confirmed that there was insufficient evidence at that point that the benefits of screening outweighed the potential risks. I am happy to go into some detail of its rationale for that. The Royal College of Obstetricians and Gynaecologists (RCOG) in the United Kingdom, also on the basis of the evidence, does not, at the moment — that is important to emphasise — recommend screening, nor does the National Institute for Health and Care Excellence (NICE). We know that 60% of the early onset group B strep, which is babies presented between nought and 90 days, are babies born to mothers with risk factors, such as the premature rupture of membranes, a long rupture of membranes etc. The current guidance to professionals, midwives and doctors is in relation to identifying those at risk and managing them. In 2011, we established a steering group, which is still active. There are three main areas of work: education, which is both professional education and the education of mothers; surveillance and notification, which concerns your point about diagnosing and picking up; and research and development. The recommendation from the UK National Screening Committee is very important; it said “insufficient evidence”, so it is incumbent on us
to find the evidence. We just do not say, “There’s no evidence, so we don’t do anything”; we need to inform the evidence base.

At that stage, the RCOG produced further guidance. We translated that into the maternity handbook. It is available on the Public Health Agency (PHA) website. We work very closely with midwifery colleagues in the PHA and throughout the trusts. It is also on the Northern Ireland Direct website. We developed a matrix for the management of individual women at risk of group B strep as identified by the RCOG guidance. We ran a joint workshop with the RCOG and the Royal College of Midwives (RCM). I spoke at that. Some women affected by group B strep very courageously shared their very painful experiences. In April 2013, I introduced the mandatory reporting of all positive group B strep isolates. That does not happen in any other part of the United Kingdom. We currently have a British paediatric surveillance survey, which is happening on a four-country basis. Independently, I commissioned the guidelines and audit network (GAIN) to audit how effectively professionals were following the guidance. That was published and shared nationally back in 2013. An ongoing audit is being carried out by the RCOG at the request of the UK National Screening Committee. We are involved here in Northern Ireland, working with a company called BioKinetic on the development of a potential vaccine. We have a major meeting in London coming up in September. As this issue arose in Northern Ireland, I have raised it with my counterparts in the other jurisdictions, and we have a major event coming up in September. We are looking at the natural history, because we do not fully understand it. We do not fully understand the transmission. We know that some women will have group B strep and have a healthy baby. We know that others, even if we test at the time of labour, will be negative, and then their baby will go on to develop group B strep. Unfortunately, so much about this is uncertain, which is why the position at the moment is a cautious one. Another area that is going to be discussed at the conference in September is the potential for trial of a vaccine.

We do not have any answers in and around the future in relation to the point that you made about screening and treatment. Before getting to a pathway where we would recommend intravenous antibiotics to a woman in labour, with all the potential consequences — maybe beneficial consequences, although there is no evidence at the moment, but also the risks associated with that — we want to be absolutely certain about the evidence. I reassure you that we are in that space. It is a very active and live issue for us.

I am conscious of your time. On cervical screening, you may be aware that we have taken advice from the UK National Screening Committee. It is something that the Chair raised in the past, around the move from cervical cytology to HPV (human papilloma virus) testing. Cervical cytology — that is the smear test — detects a number of very minor changes, particularly in young women, which is why the age for cervical screening is 25. Those minor changes often cause a great deal of anxiety, and 70% to 90% of them disappear spontaneously. In the past, we subjected women to colposcopy and biopsy, often unnecessarily. The HPV virus is the major cause of cervical cancer in about 90% of cases, and we know the particular types of the virus that pose the most risk. I chair the Northern Ireland Screening Committee, and I have tasked the Public Health Agency to look at the feasibility, logistics and resource implications of moving to HPV testing, which I think will be more acceptable to more women than cervical cytology.

It goes back to the point that I made about health inequality. With cervical screening, if you live in the right part of town, you go for your cervical cytology on request; the challenge is in the more deprived parts of Northern Ireland. There is a lot of very targeted work being led by the Public Health Agency, working with the trusts, using community resources and nursing staff to encourage women and working with the cancer charities and their buses to bring cervical screening into those areas and offer the opportunity to women there. We have a significant challenge in increasing uptake, particularly in deprived areas.

Ms McArdle: Obviously, where you live is an important factor in how you access the service, but there are also lots of vulnerable groups, particularly for things like cervical screening. I think of ladies with learning disabilities or mental health problems for whom it would not be top of their list of priorities. It may not even be in their emotional space to think about the need and plan for it. They are groups that we must engage with differently and better. There is no question that much of this is nursing-dependent. In nursing, we have workforces in learning disability and in mental health that absolutely have the opportunity to maximise their contribution to public health and not just the mental health space that many of those women are in. I just wanted to add that as a particular area for focus in terms of vulnerable groups.
The Chairperson (Ms P Bradley): We have to remember there is a plus side to this too, because of the uptake of the HPV vaccination. At some stage down the line, if all young women took up that vaccination, we could eradicate this disease.

Ms McArdle: Yes.

The Chairperson (Ms P Bradley): As you know, Michael, this is something that I have championed for a long time.

Dr McBride: I know that, Chair, and I think you are absolutely right. Our vaccination programmes are second to none for uptake.

The Chairperson (Ms P Bradley): Brilliant.

Dr McBride: Increasingly, with new technology and the advances in healthcare, some of which I mentioned earlier, we will see diseases that we are currently treating become diseases of the past, because we have developed vaccines — either the current vaccines or genomic vaccines — that will treat some of the underlying genetic predispositions.

The Chairperson (Ms P Bradley): I will not mention the HPV vaccination for boys at this stage.

Dr McBride: Well, you can. That is a recommendation by the UK National Screening Committee and there is a pilot in England, Scotland and Wales. Sorry, this is a recommendation that men attending genitourinary medicine (GUM) clinics — men who have sex with men — would have a HPV vaccination. There is no recommendation yet for heterosexual males. Again, that is because of the link between HPV and certain forms of cancer. There is a pilot in England at present that we will closely monitor, and there is a commitment in Scotland and Wales. We just need to identify the logistics associated with a move to that, subject to any decision by the Minister and the associated resources.

One final thing, because you made a very important point on mental health and self-harm. You will have an opportunity to see the Protect Life 2 — our new suicide prevention strategy — policy document. It has been going through a period of extensive pre-consultation engagement and will go out, subject to the Minister’s consideration and approval, for consultation over the summer. You will not be surprised that self-harm, given the association between repeated self-harm and increased risk of suicide, will feature prominently. The work of colleagues in PHA with local community groups is commendable. I do not underestimate the challenge. It has been an extremely challenging period and remains so. Approaches that use the information in the registry by linking it to other registries will certainly feature prominently.

The report this morning pointed clearly to the need to reduce stigma. Again, just to reassure the Member, the Public Health Agency is working very closely with Niamh, one of our mental health charities, on a three-year programme to do exactly that. Obviously, the recommendations from the report will feed into that.

One of the other important points you made was on cross-departmental working. We will not implement Making Life Better without working across different Departments. In the area of self-harm and suicide, working with the Department of Education is crucial, and that is why the I Matter programme, which is, again, about building emotional resilience, has been developed jointly with colleagues in the Department of Education and the two previous Ministers. We need to build that emotional resilience and ensure that our young people in school are signposted into the services and are aware of the signs to look out for in their peers.

As Mark will be aware from his previous role as Minister, there is significant cross-departmental working going on in the whole area of mental health and suicide. We spend £8 million a year on suicide prevention, £7 million of which is in communities and community services. It is a significant commitment, and on top of that we have all the treatment and support services.

Mrs Dobson: I thank you both for your presentations. I have almost as many questions as Catherine. First, I have been vocal about the meningitis B vaccine. We had a great victory last year. Can you update us on the uptake of the vaccine for babies? There has been a shortage of the Bexsero
meningitis B vaccine in the private sector. Are you aware of that and can you give us an update on the possible health effects for those who want to privately immunise their children?

I note your priorities, Michael. The third is research and innovation, and that is very much to be welcomed, but I think that we need to ensure that vaccines developed in Northern Ireland can be used on people in Northern Ireland. I am thinking in particular of cancer drugs and access to them. I know that great research has been done, but as long as our population benefits.

Do you want to answer those or will I go on?

Dr McBride: No, keep going.

Mrs Dobson: Both of you spoke about Professor Bengoa, and a lot of faith is being put in his outcomes. We met him on Monday, and I raised the issue of the Department loosening its iron grip on healthcare professionals. This ties in with what you said about innovation and work that has been done — the best practice that we are not shouting about and that professionals, both doctors and nurses, are doing daily.

Specifically, I brought up with Professor Bengoa his public support for bottom-up rather than Department-led projects. What projects do you see coming forward from professionals, at their call and pace and reflecting what they want, rather than the Department? I was very interested to hear you both saying that we do not shout enough about the excellent work that is being done but which is not recognised or is maybe stifled at Department level. In your view, do we have the ability to take forward successful projects and roll them out across the system? Are we capable of expanding best practice? Those are your questions, and I have a question for Charlotte after that.

Dr McBride: OK. Actually, Charlotte might want to give a nursing perspective on the second one as well, because there is a significant piece of work there.

The first thing to say is that we are the first European country to introduce a universal meningitis B vaccine. That is to be much welcomed. We are all too familiar with the devastating consequences of meningitis B. During the whole time that that was being considered by NICE, I met the charities and engaged with families who had been directly affected.

Mrs Dobson: Families played a key role in driving that forward.

Dr McBride: They played a key role. I want to commend the charities for the all the work that they did in raising the finance issue and working tirelessly and relentlessly to ensure that the focus remained on it. I want to acknowledge that. They also ensured that there was informed discussion and debate about this, and they continue to do so.

In relation to recommendations on vaccines, as I said earlier, we take advice from the UK National Screening Committee. As I said last time, that advice is based on evidence that is kept continually under review. The committee does not just take a look at the evidence at a point in time and say, “Our advice to all the Governments is the following”. It keeps the evidence under continuous review and, if the evidence changes, the advice changes. What we know is that children under the age of one, particularly those under five months, are at particular risk. On the evidence of the benefit profile, the advice from the UK National Screening Committee was that the scientific evidence supports vaccination under the age of one. As you know, we currently vaccinate at two months, four months and at 12 to 13 months. That will have a significant impact on young babies for whom the disease has the most devastating consequences. There was not evidence that supports, at this point in time, the vaccination of older children. I am not aware that the Joint Committee on Vaccination and Immunisation is planning to change that recommendation any time soon. As you know, it also did not recommend a catch-up programme.

I nearly said that we have all been parents, but mine have grown up and are not that age. However, we all know what it is like to be anxious about something that can hit as quickly and rapidly as meningitis. I can certainly understand from a very human perspective the concern that parents have. In all these difficult decisions, it is important that, whilst recognising the concerns that parents might have, we are guided by the evidence. You are quite right that other parents may choose to pay for the vaccine and have it administered privately. There was a shortage of supply for those choosing to have the vaccine privately but not for those having it under the health service. My understanding is
that that situation is now resolving as production of the vaccine catches up. It was a new vaccine, and there was an underestimation of the likely potential demand by those wishing to have it privately.

**Mrs Dobson:** Is the situation for anxious parents who want to vaccinate their kids privately being addressed?

**Dr McBride:** I am aware of it. We are all aware of it. I have produced guidance for general practitioners advising them of the arrangements when they are approached by parents who wishes to avail themselves of a private vaccine and the circumstances in which that could be facilitated. I am very happy to be held accountable for the supply issue in the health service. The private sector and private vaccination is really a matter for the industry to address, and I want to reassure you that it is addressing that issue.

I come onto the issue of a bottom-up approach, and Charlotte will want to comment on this as well. I do not recognise the description of the Department as having a stranglehold; then again, sometimes maybe I do.

**Mrs Dobson:** Iron grip, I think it was.

**Dr McBride:** Iron grip, was it? As Charlotte referred to earlier, there has to be accountability in the system. As officials, we are accountable to the Minister and the Executive. As public servants, we are accountable to the electorate through yourselves. It is important that there is the right system of accountability, with everyone recognising that. You are right: it is about having the right balance of accountability. It has to be an accountability that is reasonable in what we expect of people and what we require of them by providing them with the wherewithal to deliver, and that has to be a reasonable ask.

**Mrs Dobson:** I was heartened that both of you referred to best practice and to the great, innovative ideas coming forward. I know that we have such ideas in my trust, but if those are not encouraged, rolled out or brought along, development will be stifled.

**Dr McBride:** I was at two fantastic events yesterday. The Northern Ireland Medical and Dental Training Association had an educational excellence event. We have the Achieve Develop Explore Programme for Trainees (ADEPT), which is a leadership programme for senior trainees across all specialties. I am not one to use hyperbole, but, quite frankly, I was blown away by the quality of the presentations. Those trainees are leading quality initiatives looking at everything from safer staff handover between doctors at the start of shifts to the regional morbidity and mortality system. One of the doctors, liaising with the Southern Trust, did a piece of work on the latter, and at the event, I, along with Carolyn Harper, the regional director of public health, said on a number of occasions, "We will make that a regional approach".

I then went from that event to one in the Northern Trust celebrating innovation and improvement there. I listened to presentations from nursing staff, medical staff and allied health professionals about quality improvement initiatives in the trust. I will not name her because she would be embarrassed, but an F2 doctor presented a fantastic piece of work that she had carried out in the Northern Trust on the safe placement of nasogastric tubes. All too often, such tubes are not placed appropriately into the stomach, despite the alerts and the advice on how to do it appropriately. The tubes can get into the lung, and, obviously, that can have catastrophic consequences for individual patients. That education and training package is a fantastic piece of work that was developed in the Northern Trust by a second-year doctor-in-training. Again, I spoke to her afterwards and said, "I want to take that and roll it out across all trusts in Northern Ireland".

I could go on with other initiatives under Quality 2020. One trust initially led on the regional morbidity and mortality system that I alluded to. That was started in the trusts, and we in the Department said, "That's a really good idea. Let's roll it out across Northern Ireland". Again, an excellent programme of work on line labelling was started in the South Eastern Trust. When lines come out, it is often difficult to know which one is an arterial line, which is a venous line and which might be a line that goes up into someone's spinal area.

**Mrs Dobson:** So, we can look forward to those brilliant examples being rolled out?
Dr McBride: There are umpteen examples. We had Professor Mary Dixon-Woods over recently, and she could not believe the number of regional programmes on quality improvement that we had put in place compared to other parts of the UK. She wants to do a specific study and report on that. It goes back to the point that we talked about, and which Charlotte mentioned, that we are small enough to get all the professionals and trusts in a room, along with the Public Health Agency and the HSCB and, indeed, linking into the Department, and say, "There’s got to be a better way of doing this. There has to be a safer way of doing it", and then we can very quickly take that forward at scale and spread it. There are umpteen examples, but from the nursing side, Charlotte, do you want to speak of some?

Ms McArdle: I could add any number of examples, but the point is that we all agree that the approach should be bottom-up. The people who know best about the changes that need to happen and how to do that are those who are in daily contact with our patients and users. Our job, as system leaders, is to support and enable them to do it. Our trust organisations have recognised the need to share and learn from one another and are much better at that. I have seen a huge change in that in only the last 12 months. Like Michael, I was at the Northern Trust yesterday morning and saw a wonderful example, from a nursing perspective, of how they are using data at ward level to predict what the shift pattern should look like. They had noticed that on a Sunday, for example, there was an increase in the number of falls; it was a regular occurrence on a Sunday. They were able to look at that data and say, "Why would that be happening?" and then change the off-duty rota, which saw a reduction in falls. Again, we are taking that regionally with the other directors of nursing and saying that we want to roll this out regionally. It will give us really good information about quality data, nutrition, observations, pressure ulcers, alongside the workforce indicators, such as whether we have enough nurses with the right skills at the right time, alongside the patient experience feedback that we are getting about their experience of care. When you can put all that together, you can come up with a very good set of indicators that describe the quality and safety of the care you are providing.

There are many others. The South Eastern Trust had a similar event on Monday, recognising its journey of improvement, and people who had undertaken projects were presenting that and awarded prizes.

Mrs Dobson: We had a Southern Trust one last Wednesday, which was excellent.

Ms McArdle: They are all in that space of working and learning. The next step is to take the best of those trust projects and make sure that we can scale them across the region.

Michael, in his role as leader for Quality 2020, has supported two prototypes in Northern Ireland — one in the Belfast Trust and one in the South Eastern Trust, looking particularly at the frail elderly and how we can support them to stay at home more quickly. Our job is to give people the tools and ability to have the skills to take forward these projects at scale. We are very keen and are working in that space.

Mrs Dobson: I have one final point, if I may, and the Chair touched on it, so I will not labour it too much. It is on workforce planning and the vacant nursing posts. You assessed that fairly well. Will you give us an update on the return-to-practice campaign and overseas recruitment? The previous Minister was looking at a regional approach to that. I think you described it as a medium-term action. I am very interested in that. I note that you talked about alerts going out to the public on safety issues. I am very aware that my trust is trying to cope with long-term sickness, and staff there are doing amazing work. I cannot pay enough tribute to them for the work they do. We have amazing staff doing amazing work, but if the health service were not failing local people, we would not be talking about reforming it. Will you outline recruitment and what you are doing to address it?

Ms McArdle: I am happy to do that. First, in relation to return to practice, we run a return-to-practice programme every year. We tend to get between 16 and 20 applicants who take that route. If you are out of practice for more than five years, you have to do a return-to-practice course to get back on to the register. So, people who have taken a longer career break for family circumstances or otherwise would use that route, but the numbers tend to be quite low. Last year, we decided to do a media campaign through local radio stations, and Minister Hamilton at the time made additional funds available for more places. In total, we had 90 places available through what we do on an annual basis and the increased funds. That has been very successful. I do not know the exact number, but in the region of 70 nurses have undertaken return to practice. We are working with the university to see if there would be enough interest in running a similar programme again or whether there is only a small cohort of people in the system who would use that and whether you run that additionality every couple of years. We are working with the university to get some feedback around that.
In relation to overseas recruitment, there is an overseas programme in place. There is a regional steering group, which my deputy chief nurse sits on, and a working group. They have recently been to the Philippines for a week, and they have had a very successful recruitment campaign. When I say that, it is a conditional offer. There is a long process between that and having somebody on the ground working as a staff nurse in one of our services. It will take between nine and 11 months to see people on the ground, primarily because they have to undertake clinical assessment skills to get on the register, and they have to go to Northumbria to do that. They also have to complete an English language test at international English language testing system (IELTS) level 7, which, I understand, is a higher level than GCSE English. That takes a significant amount of time.

We plan to bring those nurses to Northern Ireland between November and January and recruit them as healthcare support workers to enable them to get the feel of working in our system, to develop their clinical skills and to improve their English language before they go to the NMC to complete their training.

We are also exploring EU opportunities. There has been a campaign to Romania, which was unsuccessful, and there is a planned trip to Italy in two weeks' time looking specifically at Italian nurses and, potentially, those who may have a paediatric qualification.

Mrs Dobson: It is quite daunting; I passed a nursing home yesterday, and there was a sign saying, "Nurses urgently needed". It is quite alarming to see that we have got to that stage.

Ms McArdle: It is a difficult situation for the nurses in the independent sector. They are recruiting from overseas, getting nurses in and training them up. The nurses are working in the home, but when the trusts advertise, many of those nurses want to get different types of experience to take back to their home countries, so they will opt to work in the trusts. This time, for the international recruitment, we have decided to run a parallel process because, at the end of the day, we are all one big system. We rely heavily on the independent sector to care for many of our older people, in particular, with complex needs. We have to take each other's needs into account. They are running a parallel recruitment process with the same agency that is working with HSC to see whether we can have a slightly more joined-up approach.

Mr Carroll: I have a few questions as well — it is one of those days — mostly for you, Michael. It says in the annual report that, I think, £20.2 million of savings need to be made by the trust. Where do you intend those to come from? Page 40 of the annual report mentions the closure of the Whiterock and Everton mental health centres. That is something that I —

The Chairperson (Ms P Bradley): That is from the last time that you were here back in November —

Dr McBride: That is not my annual report as Chief Medical Officer; it is from a different area of responsibility.

Mr Carroll: It was in our packs for today, Chair.

The Chairperson (Ms P Bradley): Yes, but we were given it in our packs from a previous briefing in November 2015. Those were the saving plans for the health and social care trusts. We can maybe talk about that with the trusts.

Dr McBride: You will have an opportunity to question at length —

The Chairperson (Ms P Bradley): Not in your role as the Chief Medical Officer, but in your next hat.

Mr Carroll: Will that be the next session?

Dr McBride: Yes.

Mr Carroll: OK. Right. Apologies, Chair —

The Chairperson (Ms P Bradley): That is fine. No bother, Gerry. Is there anything else that you want to ask?
Mr Carroll: No; I will wait until the next session.

The Chairperson (Ms P Bradley): OK. No problem.

Ms Bradshaw: Thank you very much for the presentations. Some of the questions that I was going to ask have already been answered, so I will not repeat them. I was pleased to hear you talking about advanced nursing practice in terms of supporting GPs and the allied health professionals. Looking more at the triage system, whether GP practices will depreciate is another thing. I am concerned about the pressures on the GP workforce and the rising age profile of people, comorbidities, polypharmacy and stuff. What mechanisms are being put in place to deal with the pressures from a growing population, more diseases and reducing GP numbers?

Dr McBride: The point that Charlotte made is very apt. There is absolutely no doubt that there are significant challenges throughout the UK regarding general practice. The good news story is that we are all living longer, but we are not necessarily all living longer and healthier lives. A consequence of that is the number of really old people — those over the age of 85 — with multiple comorbidities. We are not talking about two long-term conditions; we are talking about three, four or more. Obviously, there is then the requirement to be on multiple treatments, multiple interventions and support from our specialists and teams. It is ever-demanding. We have seen a significant increase in demand on general practice, but we have not seen a corresponding increase in the resource available to it. That is well understood. It is very well reflected in the relatively recent report of the Royal College of General Practitioners on the future of general practice. That was a very thoughtful piece of work.

Then the Minister made a number of announcements on dealing with some of the pressures that GPs face. As Charlotte indicated, they are twofold: seeing and caring for individual patients and the increased demand associated with repeat prescriptions and all that. The previous Minister announced £54 million over a five-year time frame to put community pharmacists into general practice to support general practice in prescribing and to remove some of the burden, as Charlotte said, so that we ensure that GPs concentrate on the elements of care that they, in their expert role, are well placed to concentrate on. The other element is that the Department recently reviewed primary care. Charlotte was a member of the working group, so I will leave her to say more on that. Specifically, we reviewed what we will need to sustain general practice and what a new model of primary care might look like, particularly the skill mix.

We have an ageing general practice population, with a significant percentage over the age of 55. We have significant challenges in certain areas, particularly in Fermanagh, where there are a number of very vulnerable general practices, and, indeed, even closer to home. As a Department, we are working closely with the British Medical Association (BMA) and the Royal College of General Practice (RCGP), looking at a wider strategic plan for how we might support the current service. It needs support and additional investment, and, although it has had some, there is more that we need to do. We have increased the number of training places in primary care, for instance, from 65 to 85. That was very much welcomed, but it will take time for those individuals to come on stream.

More broadly and fundamentally, it requires us to look again at the model of primary care. Charlotte will comment on the approach adopted by some of the Scandinavian countries.

Ms McArdle: I do not think that there is one answer to this; rather, a multiplicity of approaches is required. I was, as Michael said, part of the primary care review group, and there is absolutely a need to increase the availability of GPs, but we also need to improve the experience of doctors who go on to the GP pathway to ensure that, at the end of it all, they feel supported and will stay. That goes back to our initial point on supporting staff in the health service, regardless of their role or professional background. There are measures in place to support them in their professional development, leadership capacity, ability to do the job and ability to flag and raise concerns when things are not working well for them. Mechanisms are in place to do many of those things through the primary care workforce review. It has commissioned a programme comprising leadership development, an increase in training places and the opportunity for mentoring roles in primary care. Alongside that, it is about the skill mix, and we have already talked about advancements in practice and advanced AHP roles. It is also about a greater connection with the wider community team and the model provided to the community team. That comes via community nursing; district nursing; the practice room; the treatment room nurses; and the voluntary and community sector. It is about looking at the whole model and who is best placed to deliver specific elements of care to the patient, or client, in their home.
In some Scandinavian countries, patients see their GP a maximum of once or twice a year. In between, they see other practitioners, particularly patients whose long-term condition requires management. Often, it is more appropriate for another practitioner to see such patients. They might need more time for education, training and support; there may be broader family issues; or there may be financial problems. There are all sorts of issues that other people are best placed to deal with, freeing up GPs to see those who, if not seen within a number of hours, would present at an emergency department and be admitted to hospital. It is about a whole package of support, and I think that it is also about using ICT in real time — having appropriate, effective and relevant information available so that professionals can make informed decisions.

Ms Bradshaw: I have a few more questions, but this is the most important one: just this week, a communication landed in my inbox, seeking my support for cancer drugs in Northern Ireland being available from GPs. What are your thoughts on that?

Dr McBride: There has been a lot of high-level lobbying on that. Northern Ireland has a mechanism of individual funding requests for drugs not currently approved by the National Institute for Health and Care Excellence. Individual clinicians who feel that they may be of benefit to their patients can make a case on their behalf, and those drugs can be funded. That is the current mechanism in Northern Ireland. At the request of the then Minister, I carried out a review of the individual funding request mechanism, because there were concerns about consistency across the trusts and about the openness and transparency around that. The review also related to the cancer drugs fund that had been available in England and, to an extent, Scotland. There was a range of views in the published report of the review. We proposed a two-stage mechanism: a regional group and then a subgroup, which would also be clinically led and consider all the applications. One of the recommendations linked the development of a cancer drugs fund in Northern Ireland to the potential reintroduction of prescription charges. Views were split fairly evenly on that: about 50:50. We have yet to put prescription charges and the individual funding request process to our new Minister and discuss her views on the way forward.

On the wider issue, these are difficult decisions. Generally, we are talking about drugs, many of which are extremely costly, that prolong life by a matter of months. We cannot lose sight of the very human aspects of this, but, equally, we need to be mindful of making our decisions on the basis of the population. As a healthcare system, we make decisions informed by the best evidence available on how to make the most effective use of resource. I do not think that there are any easy answers. These drugs and the associated costs will increase, and our ability to do more in the health service will increase. We need a process whereby we reassure the population that we have a mechanism to make available to patients drugs approved by NICE as cost-effective and beneficial, where there are exceptional circumstances. There was a lot of concern about the word “exceptional”, which is why I suggested that it be removed. There needs to be a process for looking at cases on their individual merits in a transparent way. The Committee will probably receive further letters on this. The reality of modern healthcare is that, with finite resource, there will be difficult choices and decisions to be made. It is important that individuals are fully involved in that process and feel that it is fair, reasonable and transparent. We also need to be cautious. We work very closely with the industry, but pharma has other drivers in making drugs available, and we need to be mindful of that.

Mr Middleton: The areas asked about have been very well covered. I thank you both for your presentations. It has been a useful discussion, and, over the next five years, as long as we are on the Committee, we will, of course, try to work as closely with you as possible. I agree with Catherine about how well the booklet has been well produced. It is very useful in helping, certainly me, to take the information in.

I would like to look at the Protect Life strategy, suicide prevention and mental health issues. The number of people presenting at emergency departments having self-harmed continues to increase, and many of them have self-harmed previously. That is very sad, and it leads to my point that there is a need not only for strategies — they are important — but to provide the resources for what the strategies contain. My constituency of Foyle has one of the highest rates of self-harm in the UK and Ireland. We feel that the strategies are important but that resources are needed for, for example, a crisis intervention centre. I want to get your feelings on that and on how we can effectively back up the strategies.

We welcome the new legislation on psychoactive substances that came in just a few weeks ago. How do you see that playing out? Obviously, it is too early to tell now, but the PSNI has acted to tackle head shops.
Dr McBride: I will start with your last point. I very much welcome the introduction of the legislation. There is no magic bullet for new psychoactive substances. We need to stop calling them by the name that I will not mention. They cause real harm and many are illegal — they were in the past and they are now. It is important that we use legislation appropriately and proportionately, and I believe that, in this case, we have. It sends a clear message that these drugs are not safe to use, and it will restrict their manufacture, distribution and supply. There are significant custodial sentences at the discretion of the courts for circumstances in which they feel it appropriate to impose them.

The Public Health Agency has produced information leaflets and put on its website information on the implications of the legislation. I very much welcome that, but it is important that we continue that, along with efforts to raise awareness and educate people in the dangers and harm that they cause. We have a very effective approach to this in Northern Ireland through our new strategic direction on drugs and alcohol. We worked very closely with community-based groups and drug and alcohol teams on the second version of that. We also have a very robust drugs and alcohol monitoring information system that alerts us when any problems arise with a new drug arriving in a community and causing harm. It used to be in the Department and is now in the Public Health Agency, and any information or intelligence is shared widely across the system, as well as with PSNI colleagues. I welcome that fantastic legislation, but it, alone, is not the answer. There is no one answer to this. It will require our continued efforts.

Northern Ireland can, rightly, acknowledge the progress made. It was three previous Ministers, from memory, who flagged to the Home Office the approach being taken in the Republic of Ireland. Northern Ireland has played its part in the introduction of that legislation nationally. That was down to working closely together here, contributions from elected representatives in Northern Ireland to the debate, as well as, poignantly, from mothers who tragically lost children as a consequence.

I agree with you about self-harm. It is not often talked about, but it is the fifth most common cause of hospital admissions in the UK. That which will not be talked about needs to be talked about, and those who are so emotionally distressed that they feel they have no recourse but to self-harm must feel that they can ask for advice and support. We need to do much more about reducing the stigma associated with it. You are correct in saying that the Public Health Agency has been working closely with our trusts to ensure that, when individuals first present requiring medical care following self-harm, they are treated in a sensitive and appropriate way. We need to begin to ask ourselves questions such as the one that you posed: is an emergency department necessarily the best place? Certainly, those who have self-harmed require an initial medical assessment, which often requires them to be seen in an emergency department, for reasons that are clear.

The Public Health Agency has been very active in this area, and we have used the information from the register, which is another initiative from the Republic of Ireland. Its national register was put in place in 2002. After piloting it in the Western Trust, which covers your area of Foyle, in 2007, we rolled it out across Northern Ireland from 2012. We have two reports: one from 2012-13 and one from 2013-14. It is early days for us to establish trends from the register, but it allows us to begin to get a handle on the pressures on our services. This goes back to Ms Seeley's point that there are probably individuals whom we do not know about who self-harm but never come anywhere near an emergency department. Notwithstanding that, the register allows us to inform policy and ensure that we make this work central to our new Protect Life strategy. The Public Health Agency ran a major workshop in February of last year, at which carers and people who self-harm talked about their existing experience and how services might be improved. The agency introduced a new service last October — the self-harm intervention programme — which is currently available to people over 18. I know that the PHA is working with trusts, in each trust area, to ensure that it is available to 11- to 18-year-olds. The 'Northern Ireland Lifestyle and Coping Survey', published in 2010, indicated that 10% of 15- to 16-year-olds in Northern Ireland have self-harmed, which is a frightening and troubling statistic. That, combined with the challenges of suicide and the fact that there is a 25% greater need in mental health services in Northern Ireland, is a significant issue. It reflects Catherine's point about the importance of mental health and the challenges that we face in improving the mental health of the population of Northern Ireland. Only by working across government can we address the issue, and the new Programme for Government, a very much outcome-based approach, provides a unique opportunity to do that.

Mr Durkan: I think that everything has been said, but not everyone has said it yet. I will touch on a few issues, Michael and Charlotte.

I refer to another terrace chant. Michael, you said, "We're not Brazil, we're Northern Ireland"; it was a bit like watching Brazil last Saturday, which does not have the same connotations as it used to. You
spoke about the political consensus that heralded the commencement of Bengoa’s review. I am sure that neither of you are naive enough to expect that any future decision by a Minister or trust, maybe pointing to Bengoa as cover for it, will be met with the same consensus.

Workforce planning has not happened overnight — it is like ‘Groundhog Day’ — it has been a recurrent news item over a number of years. We have heard it discussed before with a sense of urgency; today, I detect a sense of panic. Charlotte mentioned a couple of initiatives from Simon Hamilton over the past year. What has taken so long for action to be taken? The extra 100 places are extremely welcome, but it will take time for those people to come through the system. Is that now in place? Are the 100 places a one-off, or will they come every year?

**Ms McArdle:** It will be for our new Minister to decide where we can increase the number and through what routes. Also, whether we need to sustain that number will depend on the outcome of many of the initiatives. I have not yet had the opportunity to have that dialogue with her.

**Mr Durkan:** Looking at the workforce planning, I wonder whether the pressure is more acute in some geographical areas. If so, is there any correlation between health inequalities, which we have to tackle, and areas where such pressure exists? I know that there will be a regional approach to recruitment and that there is a “world tour”. When the nurses, hopefully, are identified, recruited and trained to the requisite standard, will it be every trust for itself? Say, for example, that half of them decide that they want to stay in Belfast, leaving the west still with a deficit?

**Ms McArdle:** No, Mark. It is a regional programme, and all trusts are engaged in the regional working group. As the nurses come to Northern Ireland, we will facilitate, on the basis of need, where they will work. The number of vacancies will be aligned to the number of nurses coming into the system, regardless of which geographical area that is. We have put in place a regional recruitment process for dealing with regional specialties and smaller groups — for example, paediatric nurses. The Belfast Trust has the Royal Belfast Hospital for Sick Children, so it has the scope to recruit all 55 paediatric nurses being trained. That would mean, however, that the other four trusts were left without any paediatric nurses. There is now a regional programme in place to prevent that very scenario.

**Mr Durkan:** OK. I suppose that the Department is exercising an iron grip in that regard.

**Mrs Dobson:** You are stealing my phrase.

**Mr Durkan:** There was a dispute over whether the phrase was iron grip or stranglehold. I would like the Department to exercise an iron stranglehold when it comes to one aspect of healthcare. I am all for the free movement of labour, but we need some type of intervention to address the difficulties across the North, particularly in some areas, in attracting and then retaining staff and the consequent pressures that that is putting on those areas in terms of their expenditure on locums. The proportion of the budget being spent on locums perpetuates the health inequalities that we have been talking about.

I welcome the suicide prevention strategy and the fact that it will go out for consultation. It is important that the consultation is as wide, deep and well advertised as possible. Suicide is such a huge problem in the North, right across this island and beyond. There is such a feeling of helplessness out there about it. People look to politicians for answers, asking, "What are you doing about it?" They say, "You are not doing anything." You have outlined some of the very good work that is being done. We need to talk more about the good work that is being done in that field in particular, because, the more that we talk about it, the more that people out there become aware of the existing services and support. Gary referred to the particular pressures in our city, and I, too, will be parochial. Last night, there was the very sad news that a former teacher of mine — a current teacher of my son’s — went off the Foyle Bridge, taking their own life. That will have huge repercussions for the school, and I am sure that support will be in place for the pupils and staff there.

**Dr McBride:** I will comment on one point before we conclude. If the Committee allows me licence for a moment, I want to come back to the point about political consensus. I beg your indulgence, but this is my tenth year as Chief Medical Officer, and I have been up close and personal to issues that can get very political. Mark, I agree with you that it is naive in the extreme to think that we can take politics out of health: how could we when it touches the lives of so many who have elected you to represent them here?
Previously, I made the point publicly, in my annual report, that everyone has a part to play in this. The opportunity that we now have and the challenges that we now face matter too much. There are issues that we just cannot duck. I respectfully suggest that it is incumbent on all of us to play our full part in ensuring informed public and political debate. Indeed, I would be the first to put my hand up and acknowledge that we, in health, have not necessarily been very good at that all the time. Maybe we made assumptions: it seemed to us so obviously the right thing to do that we assumed that everybody else would agree. There have been times when we have not explained or communicated terribly well. There have been times when we have not necessarily brought our staff with us. There have certainly been times when we have not brought with us those who depend on and use our services. We have had a statutory responsibility to have patient and public involvement since 2009, and we need to give real effect to that.

I gave you three priorities. My fourth wish would be that, at a time of significant challenge and opportunity, we do not miss this opportunity by overly and unnecessarily politicising it. Challenge is vital, essential and important to inform discussion and dialogue. As Jo-Anne said, the Committee had an opportunity to meet Professor Rafael Bengoa: he, as a former Minister, understands the challenges of change in the political context.

The Chairperson (Ms P Bradley): OK. That is a good note to end on. Michael and Charlotte, thank you very much not only for your business area overview but for giving detailed responses to members. We appreciate that.