



Northern Ireland
Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Workforce Strategy: DH Officials

27 February 2020

NORTHERN IRELAND ASSEMBLY

Committee for Health

Workforce Strategy: DH Officials

27 February 2020

Members present for all or part of the proceedings:

Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Sinéad Bradley
Ms Paula Bradshaw
Mr Gerry Carroll
Mr Alan Chambers
Ms Jemma Dolan
Mr Alex Easton
Ms Órlaithí Flynn

Witnesses:

Mr Peter Barbour	Department of Health
Mr Andrew Dawson	Department of Health
Mr Stephen Galway	Department of Health
Mr Chris Wilkinson	Department of Health

The Chairperson (Mr Gildernew): I welcome Mr Peter Barbour, Mr Stephen Galway, Mr Chris Wilkinson and Mr Andrew Dawson, who are all from the workforce policy division in the Department of Health. I invite all our men from the Department to please brief the Committee.

Mr Andrew Dawson (Department of Health): Sure. Thank you very much. I realise, belatedly, that we have a diversity thing going on here.

The Chairperson (Mr Gildernew): I think so. Yes.

Mr Dawson: Thanks. I have an opening statement that covers some of the issues. Would you like me to go into it?

The Chairperson (Mr Gildernew): Yes, absolutely. Thank you.

Mr Dawson: Thank you very much for your time. I believe that you have the briefing note that we submitted last week. This is a general briefing on the health and social care workforce strategy. The first thing that I would say about that is that, for these purposes, "health and social care" is lower case. While we have Health and Social Care (HSC), which is made up of the trusts and other arm's-length bodies (ALBs) of the Department, we also recognise the contribution of the independent, voluntary and community sectors. The strategy takes account of their contribution now and the contribution that will be required in the future.

The workforce strategy was published in May 2018, and it was one of the outworkings of Professor Bengoa's report 'Delivering Together'. To remind you, he said of workforce planning in the report:

- "• A large section of the workforce, clinical and non-clinical, feels disempowered and not properly supported to do their jobs to their full capacity.*
- Innovation and quality improvement are subordinate to daily fire fighting and crisis management.*
- The current acute model relies heavily on expensive locum and agency staff. The medical workforce can no longer provide the level of 24/7 care required to safely deliver the existing configuration of hospital and primary care.*
- The workforce is still fragmented in silos and divided by administrative and professional boundaries.*
- There is significant untapped potential in the community and voluntary sectors."*

That is the backdrop, essentially, to the development of our strategy, and it was developed following a wide-ranging co-production exercise right across the health and social care sector. That included our own HSC employers as well as the independent, voluntary and community sectors, trade unions, regulators and other interest groups. The aim of the strategy is that:

"by 2026, we meet our workforce needs, and the needs of our workforce".

In practice, that means that not only do we have to ensure that a reconfigured and transformed health and social care service has the right numbers of appropriately trained staff and the right skills mix but the Department and employers have to provide the conditions so that we are an employer and a trainer of choice. That recognises that our health and social care sector is in competition with other sectors, other regions and other countries to attract, recruit and retain the best people. As importantly, our workers should be valued, and that includes providing the best working conditions to take account of the facts of life in the 2020s.

The strategy has three objectives to try to meet the aim, and those are detailed in the briefing paper. Briefly, objective 1 is that, by 2026, our reconfigured system has the optimum number of people in place, with the best possible combination of skills and expertise. Objective 2 is that by 2021 health and social care is a fulfilling and rewarding place to work and train and our people feel valued and supported. Objective 3 is that, by 2019, we have taken steps to improve our business intelligence. The objectives are based around 10 themes. Again, those are identified in the briefing paper, and they very much came out of the co-production and engagement that we had right across the sector when we were developing the strategy. There are also 24 actions to implement the themes and objectives, and those are listed in the briefing paper.

We have made progress in a number of areas. Action 18 in the strategy is the simplification of employment arrangements, with the first step looking at the possibility of a single employer. We have started down that road, starting with doctors and dentists in training. The Northern Ireland Medical and Dental Training Agency (NIMDTA) was identified as the single employer entity for doctors and dentists in training. In the first phase in August 2019, 100 training places went over to NIMDTA, dropping to 84 due to a number of absences for several reasons. There are scheduled to be another 252 foundation 1 doctors that go over to this new single employer on 1 April this year. Our intended completion date, which we will miss, was 1 August 2020. We will miss that, but that is because we have had problems in recruiting an IT project manager to help us to fix the infrastructure there. Whilst we will miss that, there will be further phases going over, and we are hopeful that the delay will be a matter of months until we can complete the single employer project for doctors and dentists in training. From that, we hope to be learning the lessons, seeing what issues there were in getting the doctors and dentists in training over and seeing how we might be able to roll that out further. Essentially, the reason for a single employer is that, at the moment, a junior doctor does six months of a rotation in one trust, and, if they rotate to another trust, they are, essentially, employed by a new employer. They begin their employment relationship with that employer and may have to do their generic training again. They may have to go on to an emergency tax code. None of that is designed to be helpful to attracting people into working for our system. The main reason behind having a single employer is to make life easier for the people who work there.

Moving on to some of the other progress that has been made, one of the other actions in the strategy is that we want to establish a regional health and social care careers service. That is very much complementary to what schools and the Department for the Economy provide. We want to promote health and social care, not forgetting social care, as careers. The intention is that the careers service will go into schools to promote health and social care careers, jobs and professions to young people from about the age of 13 or 14, so before they have chosen their GCSE subjects, to inform them and

try to promote health and social care as a career. It would also be the home for our budding apprenticeships policy, and that would probably live in the careers service as well. We would also hope that that would be the portal by which we could get experienced people who maybe left the service and want to return. They could hopefully contact the careers service and get a relatively seamless return.

Our education and training commissioning is also recognised in the actions in the strategy, and we have provided funding for additional training places in the past couple of years for medical specialities as well as additional preregistration training places for nurses, midwives and allied health professionals (AHPs). We have also introduced a new foundation degree in paramedic education. Those expansions are detailed in the briefing note, and we are happy to discuss those in the follow-up questions.

In addition, the Department commissioned Professor Keith Gardiner, the chief executive of our Medical and Dental Training Agency and dean of the medical school, to undertake a review of the medical student places that we need in Northern Ireland. That review was published in January 2019. It takes quite a long view ahead and recommends that we expand our supply of funded medical school places from the current 236 a year by at least an additional 100 places a year.

Workforce planning is something else that we covered in the strategy, and we recognise that needs a much more strategic approach. There are, again, two legs to workforce planning: the day-to-day workforce planning that is done by trusts and by ward managers etc in hospitals; and the strategic look for which the Department, the Public Health Agency (PHA) and the Health and Social Care Board (HSCB) are responsible. I fully admit that our approach needs to be much more strategic, and we are trying to do that through the strategy in order to improve our approach to workforce planning.

A number of workforce reviews are under way, and, increasingly, the focus on that has been on moving away from individual professions to a multidisciplinary or programme of care approach, which, again, reflects the nature of how services are and will be delivered. We have embarked on a series of workforce reviews that cover all allied health professions, and that work is ongoing. Some reviews are in final draft form, and others are nearing completion. Several have gone through the steering group and secured its endorsement and include, for example, those dealing with art, drama and musical therapy, physiotherapy, podiatry, prosthesis and speech and language therapy. We are taking some of those for sign-off to our departmental top management group meeting scheduled for Monday, and those findings will inform our considerations of future commissioning, which are decisions that are usually taken around the middle or end of March each year.

Our problem there is that, despite the fact that the need has been identified in those reviews and, indeed, in many previous workforce reviews, sometimes the resources are not available either in their entirety or in parts. Therefore, a number of workforce reviews have not been properly implemented in the past or have been partially implemented or implemented over a long period of time, which is not what the authors of those workforce reviews originally intended. However, those are the facts of living with single-year budgets and with constrained budgets.

We have also commenced a social work workforce review, and we are in the very early stages of starting a mental health programme of care approach workforce review. Ultimately, the intention of the findings of all those workforce reviews will contribute to the development of the optimum workforce model, which is envisaged at option 5 of the strategy.

On multidisciplinary and interprofessional working and training, we have committed to the exploration of opportunities for the introduction of new roles at action 8. I am pleased to say that the first cohort of physician associates (PAs) in Northern Ireland graduated from Ulster University in January 2019; 10 PAs secured posts across the HSC. A second cohort of 17 PA students completed their studies in January 2020, and 21 applicants, some from outside Northern Ireland, successfully applied for posts as physician associates in the HSC and are due to commence employment on 1 April 2020. Additionally, we are supporting a pilot in two GP practices, assisting them to employ physician associates as a proof of concept of their value in primary care, and we are looking at supporting a minimum of six further cohorts of physician associates.

The strategy promised to take account of the effects of the then impending EU exit, which has now, of course, occurred. As part of the strategy, and feeding into that, we established a workforce EU exit subgroup, which comprised regulators, members of trade unions and employers to, at that stage, do the contingency planning that was required before a deal was achieved. That will now look more at the

strategic issues and will probably widen out to look at the potential effects of the recently published immigration and migration policy and what that means for Northern Ireland health and social care.

Of course, this is not just about the numbers and skills mix in the HSC; it is all about meeting the needs of our workforce too, so we have committed to building on, consolidating and promoting the health and well-being of our workforce. We have completed an audit of the existing provision across the trusts, and that has come up with some interesting findings on what gaps and good practice exist. We want to roll some of that out and take a much more strategic and regional approach to the provision of that. The benefits of the service that our workers get should be uniform across the piece and not depend just on geography.

Finally, objective 3 was to improve our workforce business intelligence. The original date to achieve that was December 2019; we have done some of that, but we have not achieved it all. In line with action 22, we aligned the HSC staff survey, which was carried out last year, with some of the input in the workforce strategy. Again, hopefully the findings of the most recent HSC staff survey will benchmark the views of our staff on a number of things that we hope to address in the workforce strategy. We would be hopeful of having, and this is certainly the intention, improvements through that.

As work on the strategy continues, we have the rest of the business that attends to the workforce policy directorate, including terms and conditions, the pensions service and other work on our business as usual. The two biggest challenges to the strategy are the availability of multi-year funding to allow us to strategically plan workforce needs, workforce planning and education and training. It would be much more desirable if we were working with multi-year budgets rather than single-year budgets, because, after all, these are multi-year training courses and the costs ramp up over a number of years. Therefore, we will probably need better sight of the budget in the future to allow us to commission what we require. That is, of course, in the context of the fact that, even with multi-year budgets, there is competition for those budgets not just in the Department of Health but between Departments. It is a matter of record that our Minister and a number of other Ministers have made those points recently.

The other thing to mention is the need to reduce our reliance and spend on agencies and locums. That has got too high, particularly for off-contract arrangements. We had a very useful meeting on Monday past with employers and trade unions on what steps we can take this year and in a matter of months to try to start to reduce that and turn the ship around.

Finally, one of the outworkings of the agreement to get the recent industrial action suspended was a safe staffing agenda, which we and the Minister fully supported and signed up to as a means of suspending the industrial action. That will have its own workload that will feed in and, hopefully, help us to achieve some of our objectives. That is both a challenge in how we do it and an opportunity. I will end it there.

The Chairperson (Mr Gildernew): Thank you, Andrew. I advise everyone that the acoustics are not great in here, so I ask that people speak up. You mentioned the backdrop to all this, Andrew, a very important part of which was a press release issued along with a report by RQIA in November 2017. It raised concerns about the impact of nursing shortages. That press release stated:

"RQIA has identified concerns relating to the impact of nursing shortages."

It said that that was having an impact on the ability of small, independent services, such as nursing homes, to function. It also noted, interestingly, with regard to your last comments, that there is:

"a reliance on agency nursing staff to fill gaps in nursing".

It went on to say:

"As a result of our concerns, RQIA has notified the Department of Health of the impact of the shortage of nurses on the provision of health and social care services across"

the North.

My question is this: is that not highly unusual? Do you agree that it is unusual for the regulator to issue a statement of that strength?

Mr Dawson: I am not sure whether it is unusual in the normal course of events. It was certainly a matter of huge concern. It was not underestimated or understated in the Department. Nursing shortages are not a problem unique to Northern Ireland; they are being experienced right across the UK and, I think, globally. The question is this: how do we respond to that? Since that notification came out in '17, our nursing and midwifery vacancies and support-grade vacancies for those roles have continued to increase, so the problem with vacancies has actually deteriorated further.

Those are the effects and impacts of decisions that were taken on education and training commissioning in the past, and we are trying to address those matters in the workforce strategy, including sustainably commissioning training and education, recognising workers' needs and recognising that the HSC is in competition with other countries for nurses. A range of factors has contributed to that. The strategy is designed to try to address and alleviate those factors. Again, it is multifactorial, but, yes, it is a matter of huge concern — absolutely.

The Chairperson (Mr Gildernew): That being so, I find it unusual that it was not mentioned once in the 'Delivering for Our People' report, which was published some five or six months later. That leads me to be concerned that the report has, in a way, pulled its punches in the depth and extent of this crisis in the workforce.

Mr Dawson: I would say that it does not pull its punches. In fact, there is an entire section at the back — I was at pains to ensure that it was included — that reflects the findings of individual professions right across health and social care. Certainly, that section does not pull its punches on outlining the challenges, weaknesses and issues to be addressed in the system. We were at pains to ensure that it was not going to be a report saying, "Everything is fine" and that it needed to reflect the reality, so I definitely deny that the strategy document pulls any punches.

The Chairperson (Mr Gildernew): In the light of the acceptance of the significance of the challenges, can you please outline the next steps and the expected timeline for those steps in the process? Can you confirm whether the output of the review will have specific recommendations on the number and types of staffing levels and training places that are required to deliver the key transformation agenda?

Mr Dawson: Yes, that is certainly the intention. The purpose of the workforce review at a strategic level is for the Department to be able to determine not what our needs are now but what our needs will be in five or 10 years. It needs to be over that kind of time frame. All the things that you mentioned on the education and training that we need to commission needs to go into the equation. We need to look at attrition rates. We need to look at projected retirement rates, so will look at analyses of the age of staff over the next five to 10 years. It also looks at, basically, the need to recognise work-life balance, for example. I think that that came up the previous session. Absolutely, the system needs to recognise the need for work-life balance. That is simply the world we live in. A huge number of workers are, I imagine, caring not only for their children but their parents and other dependants. That is just a fact of life. The system needs to recognise that. The impact of that on workforce planning is that you need to increase your headcount in HSC because you need more people to cover the shifts that are, essentially, left vacant by the need for people to work shorter hours, which we entirely recognise is just a fact of life.

Mr Peter Barbour (Department of Health): I will explain the approach that Andrew outlined. We are not focusing on vacancy management but looking at long-term workforce planning. That will be increasingly aligned to transformation, so it takes into account Bengoa, the transformation and reconfiguration of services and the opportunities for innovation and the introduction of a new skills mix in the delivery of care. It is very much about not just accepting the system as it is but how it will evolve, and looking at a regional approach as well. The Committee has had a briefing on allied health professions, and our approach has been to work collectively with professionals and other stakeholders across the HSC to bring forward their ideas and to look at opportunities, for example, to enhance service delivery and ways of doing things on a regional basis. All those things feed into the mix, and, ultimately, we will bring forward a range of recommendations that can certainly influence preregistration training. It can influence routes into training and the development of career pathways in certain professions. There is a wide range of things.

As Andrew said, we are moving increasingly away from being uniprofessional — looking at an individual group only — by looking at the delivery of a programme of care and at how multidisciplinary teams can be serviced and created to provide that care. One of the areas that we are looking at, for example, is the cancer strategy. There are various stages: raising awareness; identifying signs; early presentation with symptoms; early access to diagnostic tests, which is important to allied health

professions; treatment plans; and follow-up. Those are the various steps along that care pathway, and you can imagine the range of skills that come into play and the teams of people who are involved. Increasingly, that is where our workforce planning on a strategic basis will take us.

You mentioned the RQIA report, and I have two observations. We have significantly increased our commissioning preregistration places by 45% since 2015-16, and, in light of the recent decision associated with the Agenda for Change settlement, we increased that further. Obviously, it takes a while for those people to come into the system.

As I think you mentioned, the RQIA report refers to an interesting area, which is the interplay between the trusts and, for example, the independent sector. I tend to view that as being the interdependent sector because, ultimately, we are all working together to deliver care. What has developed over the past number of years is that we need to work collectively with that sector to understand its needs. There are individual employers, which can be private organisations that recruit their staff. In some sense, in times past, there was a tension in that HSC was seen as being a more attractive place to work, and people gravitated towards our trusts. That has caused pressures, particularly in some rural and other specific locations. Over the past number of years, there has been an increasing awareness that we need to work collectively as a wider system HSC to address those evident challenges. We are a small place and are interdependent.

The Chairperson (Mr Gildernew): We get a sense that there is lots of activity, but what we need is action. I have heard some of the next steps and the linkages on transformation, but I have not heard anything about timelines. What are the timelines?

Mr Dawson: The first increase of the additional education and training commissioning was in 2016-17, and those figures have just fed through to the last quarterly figures for nursing and midwifery. There have been increases in the subsequent years, which will then be reflected in one, two, three, four years from now.

Mr Barbour: The extra 91 places commissioned became available —

The Chairperson (Mr Gildernew): Sorry. What are the timelines to action the reviews that are sitting on your desk? I am not asking about past reviews. What are the timelines for the reviews that you are in possession of now?

Mr Dawson: The reviews that we are now in possession of are some of the allied health professional reviews, which will go to our top management group on Monday for sign-off. If those are signed off, the recommendations feed into our commissioning considerations for 2020-21, which take place around the middle or end of March.

Mr Barbour: Chair, we also have a review of the pharmacy workforce, which will shortly come to a conclusion. There is quite a spectrum coming through — for example, there is a review on the medical specialty of microbiology, virology and infectious diseases, which will feed through into the education training budget proposals for next year. Obviously, delivery on those recommendations is subject to funding availability.

Mr Dawson: That is a crucial point.

The Chairperson (Mr Gildernew): We heard earlier that New Decade, New Approach has a commitment to £10 million for safe staffing in nursing but that zero has been allocated to allied health professions. Is that correct?

Mr Dawson: I will have to check the detail. As I understand it, the £10 million is in direct response to the need to fully implement Delivering Care, which is a nurse-specific programme.

The Chairperson (Mr Gildernew): Do you recognise that there are huge amounts of allied health professions who will similarly need to be factored into the planning?

Mr Barbour: Absolutely.

Mr Dawson: Not just allied health professions — all professions.

Mrs Cameron: Thank you for your presentation. We do not underestimate the complexity of the issues, and we fully appreciate the difficulties. You have already answered some of my questions about work-life balance. Work-life balance is really important so that we do not lose valuable expertise because people do not have accommodation to be allowed to continue in whatever their profession might be.

We heard from the allied health professions this morning, and the key recommendations have come from the ongoing workforce reviews. I hear that a meeting is coming up in March. Have the key recommendations been costed by the Department?

Mr Dawson: The process is that the Department first considers whether to accept the recommendations, and costings come slightly later in the policy paper that goes to the decision maker, which will now be the Minister. That will be costed.

Mrs Cameron: We will presume that the recommendations will be accepted. How long will it take to do the costings?

Mr Dawson: Presuming that the recommendations are accepted, they can be costed reasonably quickly, and certainly in time for our considerations for next year. The crucial point is that, once we identify how much it will cost, there is no guarantee that we will get the money to fund it.

Mr Barbour: Affordability comes into play, obviously. On the point about work-life balance, I should emphasise that we are following a six-step methodology in the approach that we apply to all workforce plans. One of the things that it does is to understand not only the workforce we will need to deliver care but workforce supply and the people coming through and what is needed to attract and retain them. It is a key element from each workforce recommendation. There are issues about the numbers for prereg and post-reg training, and how you attract people in and keep them, providing an assurance that that is very much a focus of the methodology we use.

Mr Carroll: Thank you for the presentation. The latest figures are 1,025 for nursing and midwifery trainee places.

Mr Barbour: That is right.

Mr Carroll: It is up 25 places on last year. Do we not need more than that? To me, the approach seems to be a bit slow and unambitious. The latest 2017 figures from UNISON state that we need 2,500 extra nurses. You said that that figure has gone up, so now approximately 3,000 nurses are needed. Is the Department's slowness to respond to our crisis an element of this? We had a briefing from the AHPs, and I got a sense from them that the Department seems to be sitting on its hands. There is a good list of demands about what is needed to tackle the shortage of OTs, radiographers and others. I just feel that the Department is not responding quickly enough to deal with those issues, so I wanted to put that to you.

The other workforce issue is about neurologists. Obviously, there is a big, big crisis in neurology. The 2017 workforce plan stated that 44 neurologists were needed. There are 21 at the minute and, of those, eight are over 50 years of age. That is very concerning. The Department's 2017 plan envisaged 16 consultants in training by 2020, and there are only nine at the minute. There is a big, big problem in neurology. Obviously, there is also an ongoing inquiry. To tackle some of the pressures on neurologists and the waiting lists, we need to rapidly recruit and train up neurologists. I would like some more detail on that. There are 252 trainee doctors at foundation level, and only two of them are in neurology to get experience and an idea of what is required. Why is the figure so low?

Finally, the pay parity issue has contributed massively to workforce issues. I have spoken to OTs, nurses and all sorts of healthcare workers. Pay parity is a major issue for them and has affected the healthcare service massively.

Mr Dawson: Commissioned prereg nursing and midwifery places are at an all-time high of 1,025, which represents something like a 45% increase over the past three or four years. You are right: we are not where we want to be with our vacancies. New vacancy figures were published yesterday, covering the quarter to 31 December 2019 and, for registered nurses, there was a decrease in one quarter, but it is still too high at 2,114. There was also a smaller decrease in the number of registered midwifery vacancies, which went down from 120 to 93: still too high. Worryingly, there was an increase

in vacancies in nursing support from 521 in the quarter to 545. There was a very small decrease in midwifery support vacancies, from three to two. Overall, the number of vacancies in the last quarter went down, but we are certainly not complacent and are not saying that that is evidence of a trend of any improvement: far from it. We appreciate any downturn in vacancy numbers, but, equally, we are not complacent.

Mr Barbour: I emphasise that point. Obviously, it takes a long time for people to come through three years' training, but, by next year, the 2020-21 training year, we will have secured an 87% increase in preregistration training places in Northern Ireland's universities, from the low that we got to in 2015-16. I hope that that gives some assurance that a supply is coming through.

We are really fortunate in Northern Ireland because a lot of people want to work as nurses and midwives. For every commissioned place at Queen's, we have eight applicants. Ulster University has six or nearly seven applicants for every place. We acknowledge that a lot of people want to get into our system. We also have extremely low attrition out of the programme. I assure the Committee that people take up posts in Northern Ireland. We undertake a destination survey, or at least Queen's does; Ulster University uses separate methodology. The survey shows that it is an extremely low percentage of people who do not take up posts as nurses in Northern Ireland. There is a supply coming through, but it will take the next couple of years to make a significant impact. As Andrew pointed out, there are signs that we are beginning to make some headway.

Mr Carroll: There is a feeling, though, that it is not being done quickly enough. You referred to the figures dropping, and you quoted four or five stats, but there are still 2,000 vacancies for nurses.

Mr Barbour: It was to show the trend.

Mr Carroll: People feel that it is not quick enough and are concerned that it is not being dealt with rapidly enough.

Mr Dawson: I accept that point. Certainly, that is why we try to supplement the longer-term strategic actions on education and training commissioning with things like international nursing recruitment.

You are right about the progress around OT, radiography and the allied health professions. There are needs there but a finite budget. Last year, we were able to increase the number of physiotherapy and radiography training places by 10 each. That still does not meet the projected need, but we have only so much resourcing. If we do one thing somewhere, we do not do something somewhere else. It is about achieving that balance. Last year, we were able to increase clinical psychology places from 11 to 15. Our aim is to get to 19, which would bring us up to one clinical psychology place for every 100,000 of the population, which is more in line with the rest of the UK. Again, I stress that there is a balance to be achieved about where the resourcing goes. It may be the right call; it may not be. People will have their views, but it is not a perfect system.

A workforce review of neurology was completed in May 2017. That recommended an expansion of the neurology medical training programme by two posts. One additional neurology post was funded in 2018-19. A number of other specialties were vying for the available resource that year, including urology, radiotherapy and anaesthetics. We had to make a balanced decision on that. Our Medical and Dental Training Agency has reported recruitment difficulties in neurology. Five of the 11 funded posts in the current training programme are vacant, and the Department cannot extend the programme until further recruitment difficulties are relieved. Based on current projections, one trainee is due to complete training in February 2021; four in August 2021; an additional one in August 2020; and two in February 2025. The neurology training component in foundation year 2 of medical training has been expanded to try to improve the student experience and, hopefully, to encourage more people to join the training programme. As you say, there are huge challenges in that specialty, among others. There are measures to try to address it, but we are very much doing what we can with the available resource.

Mr Carroll: Just a quick question, Chair.

The Chairperson (Mr Gildernew): Gerry, no. I am going to move on to Paula. I want to give everyone a fair chance.

We are very aware of the context of all that and appreciate the briefing documents, but we want to focus on the strategies and plans to address it in the questions and responses, please.

Ms Bradshaw: The briefing paper refers to the challenges, and:

"The need to reduce the reliance on, and spend, on agencies and locums, starting with off-contract arrangements."

Not that long ago, I was speaking to the chief executive of one of the health trusts — I will not say which one — and he indicated that there is legislation or regulatory change that puts a price cap on the amount that agency staff can be paid, which means that you are not getting it at 4.45 pm on a Friday and paying through the roof. To what degree do you think that the introduction of that legislation could help or hinder that process?

Mr Dawson: We all recognise that it is a huge challenge. The introduction of a price cap would be double-edged. There is a de facto price cap in place because we commission or contract and formally procure a number of nursing agencies, and they go through the procurement process.

Ms Bradshaw: I am not talking about just nurses, by the way. I am talking about *[Inaudible.]*

Mr Dawson: Absolutely. They all go through the procurement process, and part of that process is that they stipulate what rates they will charge. The problem is where the contracted agency capacity has not been enough even to meet demand, so trusts have had to go off-contract. By their very nature, off-contract agencies have not been through the procurement process and can name their price. The alternative to engaging off-contract agencies is a downturn or temporary closure of services, which is not what trusts want to do. They want to avoid that, and we fully respect that approach.

If a price cap were in place, it would rule out the emergency use of agencies. That said, the use of off-contract agencies has probably gone too far and needs to be pulled back, which is why the first stage in our intended approach to try to reduce agency and locum use.

Ms Bradshaw: You mentioned that you were going to look at the workforce and the demography in certain sectors. Can you give us an update on the community dental service review? The terms of reference went out in October. Where is that at?

Mr Dawson: Certainly. I had a useful meeting with the British Dental Association (BDA) this day last week, at which we discussed the community dental review. We had agreed to do that as part of our regular engagements, and I had circulated draft terms of reference. The BDA came back with comments. Unfortunately, that is where it has sat from November because, until recently, the vast majority of my time since then was in preparation for, and trying to avoid, industrial action. I am behind in a lot of day-to-day issues, including that one. In the meeting last week, I committed to fast progress in getting that established. We are planning a workshop in March or April for community dental care.

Ms Bradshaw: That is good to hear.

Mr Barbour: We have those arrangements going forward.

Ms Flynn: Thanks very much, Andrew, for your presentation. I want to ask about the mental health workforce review that you referred to. Will it include just statutory services or will community mental health services be involved? I am not sure that you are at that stage. Have there been any engagements with or approaches to the mental health workforce about the review?

I also want to ask about action 6: implementing and embedding the regional health and social care workforce planning framework. Does that relate to the 2015 planning framework? Has that still to be implemented? If it is 2015, after five years, should it not be considered more an approach than a target? I am asking about the time lag.

Mr Dawson: We are at the very early stages of the mental health workforce review, so I cannot go into specifics. In a previous life, I looked after mental health policy, and I recognise the contribution of the community and voluntary sector. I imagine — I do not want to step on any of my colleagues' toes — that that would need to be considered.

Mr Barbour: May I reinforce that point? When it comes to methodology, we work very closely with all stakeholders in the whole approach to workforce planning. It is not being done by some experts or whatever in the Department. Absolutely not.

Ms Flynn: OK.

Mr Dawson: Action 6 of the workforce planning framework is the six-step methodology that Peter referred to earlier, which is being embedded in everything that we do now. That action is there to keep our feet to the fire, as it were, and make sure that we continue to embed it throughout everything we do on workforce planning.

Ms S Bradley: I will keep it brief. Thank you for the presentation. In looking over the presentation and the associated papers, I cannot help but wonder at the outset whether we are having a difficulty with communication. I am pleased to hear that the meeting is happening on Monday with the AHP. Is the meeting with the steering group? Who is the meeting with?

Mr Dawson: It is the top management group. Essentially, the steering group clears the findings, and it then goes to our top management group, which is our senior management.

Ms S Bradley: Is that meeting on Monday?

Mr Dawson: Yes.

Ms S Bradley: It is about information flowing from that so that people are reassured that they have not been forgotten. There are some people who should be at that table but are not, and there is an argument to be had around that. Can some thought be given to communications so that important stakeholders, who will deliver these outcomes, are all involved at every stage and so that their voices can be heard? A lot of focus, and rightly so, has been put on encouraging people into the professions in the sector. I note that a weakness was identified in people exiting the professions. We need to capture rich information about why they are exiting, because there may be very affordable solutions to retaining people who we are missing. How assured are you that we are doing good, thorough exit interviews to build strategies around that?

Mr Dawson: Thanks for your questions. We can always do better when it comes to communication with stakeholders. I accept that we could have done better in our communications with allied health professionals over the past quarter. Again, unfortunately, I think it was a symptom of too many things going on, but I take the point entirely.

There is a specific action in the strategy to roll out exit interviews. Again, as I mentioned earlier, we are behind schedule on that objective, but it is absolutely something that needs to be done. You are right; it is a rich source of intelligence.

Mr Barbour: Without saying that this is hot off the press, I can tell you that we recently engaged with the regional healthier workplaces network that represents stakeholders and employers across HSC and which is very willing to get involved in taking forward the recommendations regarding the development of a health and well-being framework. Part of that is looking at the whole question of retaining people and people working longer in the HSC and all the issues associated with that. That, possibly, ties in with the information that you were referring to about encouraging and enabling people if they choose to stay and work longer in HSC because, obviously, that is a valuable resource of experience to us, which we do not want to easily forego. That work is being taken forward there.

There is so much going on around the issue of communication. I know that you referenced AHPs, but there are workforce reviews ongoing in dental services and in pharmacy, which is a very significant area. You will be aware of the challenges associated with that. It is a challenge, but we are really pleased that the Executive are in place and that we have a Minister to take that forward, inject momentum and focus on all those issues, and we greatly welcome that.

Ms S Bradley: I appreciate that comment because there are many people, even outside this room, who are vested stakeholders and who, perhaps, feel that they are outside the process.

Mr Dawson: May I make one further point about stakeholders? We have established — this will be a long-term endeavour — a reference group for the workforce strategy, which has very wide representation on it. They will see early drafts of things as they are being developed, and they will have an opportunity to comment, feed in, co-develop and co-produce the policies and actions in the strategy. That will give them a good opportunity to have a huge range of interests represented.

Ms S Bradley: How are individuals appointed to the reference group?

Mr Dawson: Essentially, the reference group started off as all of the membership of the steering group that produced the strategy. As we go on with the implementation of the strategy, we meet various people and offer them a place on the reference group, and we ask them to mention to anyone in their sector that if they want to be on the reference group, they can do so. Today is the opportunity to offer it to a wider audience; if you want to be on the reference group, please do.

Ms S Bradley: I appreciate that, thank you.

Ms Dolan: You said that objective 3 has not been completed. Why not? I have another question around the EU exit group. It has been meeting since 2018, so has it already reported? What are the group's terms of reference?

Mr Dawson: OK. There are four actions under objective 3. We have done one, and the others are just a question of time and having enough hours in the day to address those issues. I am a bit behind schedule at the moment with the gap analysis and what exactly we need to look at. Hands on the table, it is as simple as that. It is just a matter of resourcing.

The EU exit subgroup was not tasked with creating a product. Rather, it was about giving us real-time intelligence and input into the effects in various sectors of the EU exit potential etc. It was extremely valuable to get its insights on the potential impacts on numbers. It was very helpful in getting our communications out in relation to our work with the Home Office on the EU settlement scheme. It was very useful in getting the communications out to various sectors; we may have had trouble with that without it.

Ms Dolan: What about the terms of reference?

Mr Dawson: Not off the top of my head, but I can certainly get those to you.

Ms Dolan: Thank you.

The Chairperson (Mr Gildernew): The 2012 strategy referenced the difficulties around increasing bureaucracy in social work. That was also referenced in the 2018 strategy and other significant reports. Many of us have spoken to the British Association of Social Workers. Can you give us an update on what is being done to deal with that?

Mr Dawson: Sure. I co-chair, along with my colleague Christine Smyth, the social work workforce strategy group. It is in the process of developing a social work workforce strategy for the future. There is a workshop tomorrow, which I will attend, with a huge range of stakeholders from across social work to identify the needs for that sector. The point is very well made about bureaucracy in social work and, in fact, beyond the system as well. It is a point that has been made by NIPSA colleagues around the table on the social work workforce review.

As part of the outworkings of the framework agreement to end the industrial action, we, I think, said that there are problems in nurse retention and recruitment, AHP retention and recruitment, social work etc. There are also issues in our admin and clerical workforce, which has a high number of vacancies. The effect of that is not to be underestimated in what that, in turn, requires professionals to do on admin and clerical. There are a lot of moving parts, but the point about bureaucracy is very well made.

The other thing to say — again, not coming from a social work specialist point of view — is that the role of social workers, as with others, is always evolving and changing. Even the further implementation of the Mental Capacity Act, for example, is a new thing that did not exist a few years ago. The workforce review that we are doing at the moment will need to reflect that as well.

The Chairperson (Mr Gildernew): I should probably have declared that I have worked as a social worker, so I fully understand the difficulty. It is also about the lost opportunity in not having social workers and many of the other professionals working to the top of their ability and experience and all of that. That is having an impact across the board.

Finally, in relation to the work-permit scheme and the thresholds set in that, what assessments have you done on the impact that that will have on our domiciliary care workforce and any other elements, or what assessments are you planning to carry out?

Mr Dawson: Again, we are in the early stages. Is this the UK Government's migration —?

The Chairperson (Mr Gildernew): Yes.

Mr Dawson: We are in the early stages of assessing that. A number of pieces of that are going to be of concern to us. One is the salary threshold that was announced; we are going to need to assess what that means for us. I think that, at the moment, £25,600 is envisaged in the UK Government's policy. That would kick in at around the bottom or middle of band 5 under Agenda for Change. We have not yet completed our local considerations, but, at UK level, I think that the Migration Advisory Committee — I apologise if I am misquoting it — said that the policy may be helpful to health but not so helpful to social care, in the way in which it was announced, anyway. We are still in the early stages. I have not done a full assessment, and I would not want to speak outside my brief until I am on firmer ground.

The Chairperson (Mr Gildernew): Given that there is already a crisis in social care, and we are seeing people in hospital who should not be there — people who should be back at home, or people who are being brought into hospital but should have been maintained at home — what plans have you to challenge the Government and say, "This will exacerbate what is already a crisis here for us"?

Mr Dawson: We have regular contacts. We go through the Executive Office, I think, to have our contacts on this issue. Once we have fully assessed the policy and the implications of the policy, we have opportunities to feed back. You asked about challenge. We can give our assessment of the policy, but the question of a wider challenge becomes more of a political matter than one for civil servants, but we will be in a position to give our take on the advice.

The Chairperson (Mr Gildernew): When will you have that assessment completed?

Mr Dawson: I cannot say off the top of my head, but I am hopeful of it being soon. I can certainly firm that up to you in writing, if that would be helpful.

Ms S Bradley: It is not just employees under the threshold. The implications will have a ripple effect. If all the underpinning workforce is going to be in any way depleted, there will be huge implications. I hope it is a very wide assessment that is cognisant of that.

Mr Dawson: It will be. We have a lot of the right people on speed dial, as it were, because a lot of the same people who helped us on the EU exit work will be able to help us with this. We have some extremely helpful colleagues from the Northern Ireland Social Care Council sitting on the group who have been of great assistance on the exit preparation. I think that they will be of assistance on this work as well. It is early days. Apologies, if I have inaccurately portrayed the Migration Advisory Committee's view of the world, but that was my understanding of something I read recently.

The Chairperson (Mr Gildernew): Thank you for your presentation and for the papers that you sent to us in advance.